Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Frances Rodriguez Blumen February 2000 5 p.m. 8 4s Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Davs Hours 10 M 20 F Months 120-38-4170 March 28, 1921 Puerto Rico Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No MD **Baltimore** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1729 E. Lombard Street 21231 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc 1 Yes 2 No If Yas, Giva Year or Datas: 1 Never Married 2 Married Specify: Puerto Rican 1 Yas 2□ No 3 ₩ Widowed 4 Divorced White Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Factory 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Victorio Rodriguez Juana Roman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ted Shipley - son 6843 #1304 Old Waterloo Rd. Elkridge, MD 21075 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 St Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Voshell Memorial Gardens 2/10/2000 Dundalk, Maryland 22. Nama and Addrass of Facility 21. Signature of Funeral Service Line Cafa, Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286 23a Part Erlier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardio shock or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Immune Deficieny Syndrome Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24b. Wara autopsy findings available prior to 24a. Wes en autopsy performed? completion of causa of death? 1 Yes 2 No 1 Yes 2 No 25. Was case refarred to medical 26. Place of Death (Check only ona) examiner? Other: 4 Nursing Homa 5 Residence 6 (Dothar (Specify) Ho S N (Co 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Cortifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

that the deeth certificate be execu Records, P.O. Box 68760, e ettending p. Division of Vitai To the Hospital or Attending Physicien: within 24 hours siter death.

To the Funeral Director: After this certified completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Heelth and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or item eny injury or other traumatic event, the Medical Exemples ones.

Physician

/Medical

Examiner

physician end the burial-transit

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been signed by the should be detach

has

certificate

aitimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

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State Registrar

DHMH 16 Rev 6/95

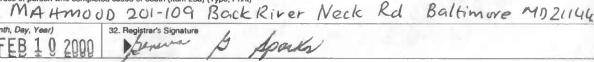
31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

1ARIQ



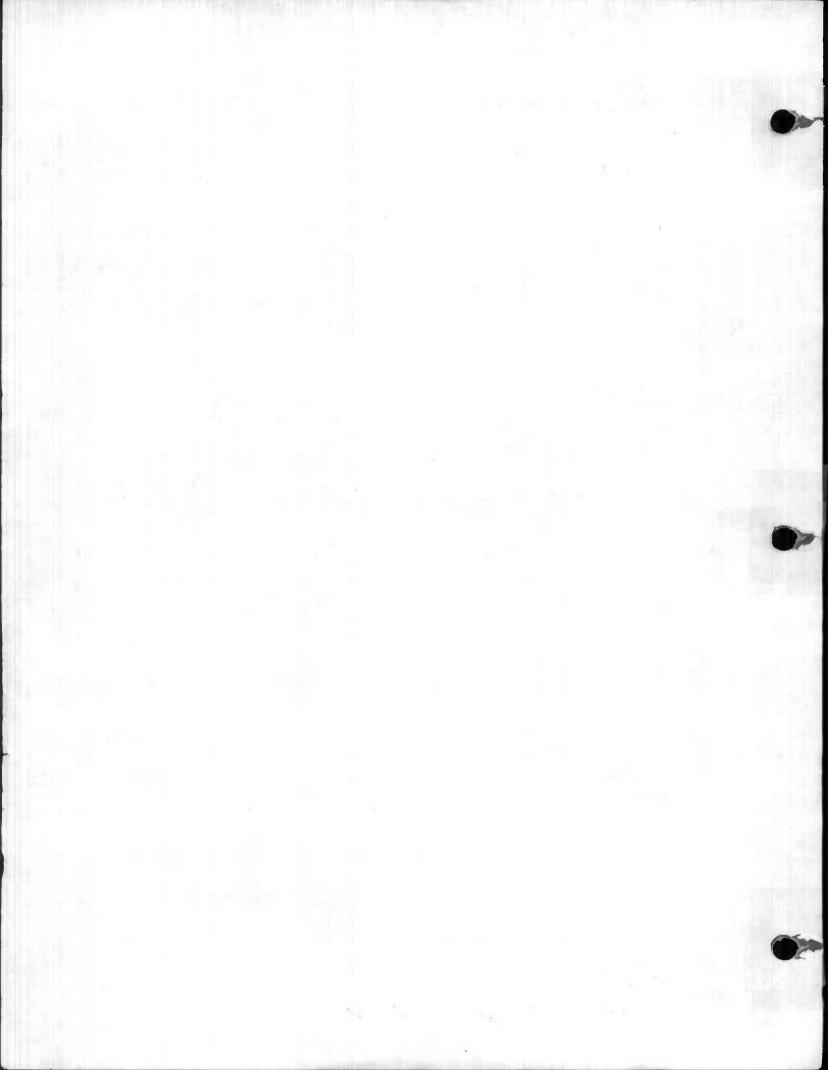


29c. License number

D43725

29d. Data signed (Month, Day, Year)

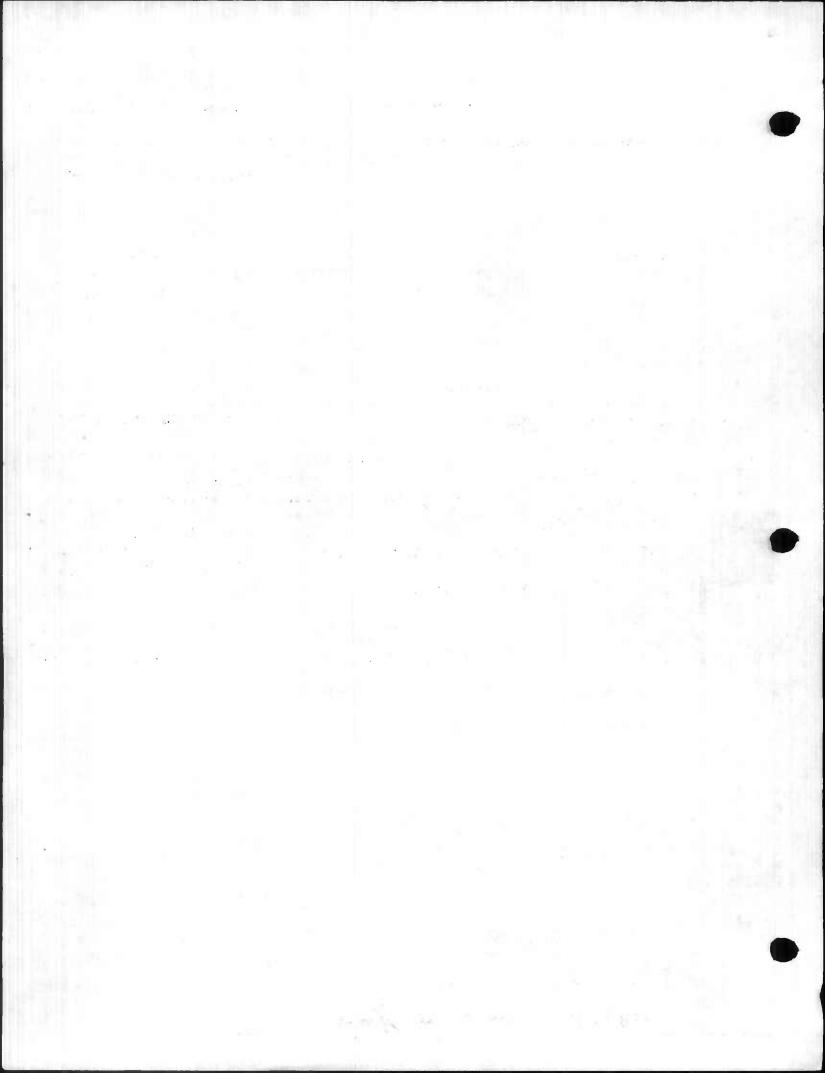
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State of Maryland / Department of Health and Mental Hygiene

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|---|---|----|---|----|-----|
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| | | | OGILIII | ale UI | Death | | - R | leg. No. | | | |
|--|--|---|---|---|---|---|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Margaret H. Benik | | | | | | | | th Day | Year | 3. Time of Death 2:00 P.M. | |
| 4a Facility Name (If not institution, gir | | 4b. City, Town | | | | | 2:00 P.M. | | | | |
| Genesis Elderca | re Hammond | ds Lane | | | Balti | imore | | Anne | e Aru | nde1 | |
| 5. Social Security Number 6. | Sex 7. A | 9X 7. Age (In yrs. last birthday) If Under 1 Year Months Days | | | | Hrs. 8. Min. | Data of Birth (Month, Day | Year) | 9. Birthpl Coun | ace (State or Foreign try) | |
| | | | | | | 15.36 | 27 207 | 1311 | LICAL | Juna | |
| 10a. State 10b. County | | 10c. City, To | wn or Location | | | | | | 10 | Od. Inside City Limits | |
| Maryland Anne Ar | undel | Balt | imore | | | | | 5 10 | | 1 ☐ Yes 2X No | |
| Maryland Anne Arundel Baltimore 106. Street and Number 106. Street and Number 107. Zip Code 21225 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yorks, specify Cuban, Mexican, Puerto Rican 11 Yes 28 No | | | | | | | 1 | | | try? | |
| | | Ever in II S | 12 Wee D | | | 2 (Specif | y Ves or No. | | | an Indian | |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces | 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ I | | | | uerto Ric | an, etc.) | Bla | Black, White, etc. Specify: White | | |
| | | 16 | a. Decedent'a | Usual Occu | pation during most o | / working | | 16b. Kind of B | usiness/Ind | lustry | |
| Elementary/Secondary (0-12) | | College (1-4or 5+) | | | id) | none ig | | Own Home | | | |
| |) | | 11011101110 | arc L | 18 Mather's | Name /F | iret Mirirlia | | | | |
| | | Villiam Herzberger | | | | | | | | | |
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| result of the state of the stat | , | | | | | | | | | | |
| | 5011 | | | | DIIVC | - | | | | | |
| 1 🗷 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗆 Other (Speci | (y) | | Hill | Cemete | ery | | | | | | |
| 1 Sonna M | Framis | BUSA od the death. Do | 4001 | Ritch | nie High | hway | Balt | imore, | | | |
| Immediate Cause (Finel disease or condition resulting in death) Coronary Artery Disease a. Due to (or as a consequence of): | | | | | | | | 1 | Onset and Death year | | |
| | Hypertension 15 years | | | | | | | | | vears | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): | | | | | | | | | 1 1 | | |
| that initiated events resulting in death) Last | U. | Due to (or as a | consequence | of): | | | | | | | |
| | d. OSCEOI | uyelit. | IS KIG | пс н | 1p | | | | 1 | 5 years | |
| Part II. Other significant conditions of | contributing to death t | but not resulting | in the underly | ing cause gi | iven in Part I. | | 23b. Did to | obacco use co | ntributa to | the cause of death? | |
| | | | | | | | 3 Prot | eably 4 Unknown | | | |
| | | | | | | _ | 24a. Was a perfor | an autopsy med? | alva cor | ore eutopsy findings allable prior to appletion of cause death? | |
| | | | | | | | 1 🗆 Y | es 2KI No | 10 | Yes 2 No | |
| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No | Hospital: 1 ☐ Inpati | ient 2 ER/0 | Outpatient 3E | DOA O | her _ | | | | ner (Specifi | () | |
| | | | . Time of | | | 1 | | | | | |
| 2 ☐ Accident investigatio | n | ny rear) | | | | | | | | | |
| | 286. Mace of In | ijury - At home, tc. <i>(Specify)</i> | farm, street, fa | ctory, office | | 281 | Location (S City or Town | treet and Numi n, State) | ber or Rura | I Route Number, | |
| | niner: On the basis of | of examination a | ge, death occu and/or investiga | rred at the ti | ime, date and popinion, death | occurred | due to the cat the time, d | ause(s) and malate and plece, | anner as st and due to | ated. the cause(s) | |
| | | | | | | | 2 | 29d. Data signed (Month, Day, Year) 02/08/2000 | | | |
| | Genesis Elderca 5. Social Security Number 219 22 9310 Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar 10e. Street and Number 613 Hammonds Lat 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last 19a. Informant's Name/Relationship (Richard Benik 20a. Method of Disposition 1 Maurial 2 Cremation 3 II 4 Donation 5 Other (Special 21. Signature of Funeral Service Licenshock, or heart failure. Lint and Immediate Cause (Finel disease or conditions are sulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions of the cause of Disease or injury that initiated events resulting in death) 25. Was case referred to medical examiner? 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 1 Could not be determined 1 Matural 5 Medical Example one) 29a. Certifier (Check only one) 1 Certifying Physical Example of the Could not be determined 1 Medical Example one) | 4s Facility Name (If not institution, give street and number Genesis Eldercare Hammonic S. Social Security Number 219 22 9310 Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10e. Street and Number 613 Hammonds Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specity only highest grade completed) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) William Ho 19a. Informant's Name/Relationship (Type, Print) Richard Benik / Son 20a. Method of Disposition 1 Xi Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specity) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or completations that cause shock, or heart failure. Lint. only one cause on each limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause on each limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause on each limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause on each limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause on each limmediate Cause (Finel disease) or condition and limber limitated events resulting in death) 25. Was case referred to medical examiner? 1 Natural initiated events resulting in death) 26. Diabetic Month, Diabetic limitation be determined 27. Manner of Death 1 Natural limitation be determined leader on the besis of the condition on the leader on the limitation of the leader on the limitation | 48 Facility Name (If not institution, give street and number) Genesis Eldercare Hammonds Lane 5. Social Security Number 219 22 9310 10 | Genesis Eldercare Hammonds Lane 5. Social Security Number 219 22 9310 1 | Genesis Eldercare Hammonds Lane Social Security Number 6. Sex 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 Under 1 Year 219 22 9310 1 M 2N F 7. Age (in yrs. last birthday) 1 M 2N F 7. Age (in yrs. last birthday with a yrs. last birthday 1 M 2N F 7. Age (in yrs. last birthday) 1 M 2N F 7. Age (in yrs. last birthday with a | Secolar Security Number 6. Sec 10 28 7. Age (in yrs. list birthday) 11 10 28 28 10 28 28 10 28 28 10 28 28 28 28 28 28 28 2 | 46. City, Town, or Local Genesis Eldercare Hammonds Lane Social Security number 219 22 9310 Usual Residence of Decedent Usual Residence of Decedent Residence Usual Residence of Hispanic Origin' (Specific If Usual Cooperation (Figure Prival) Residence of Prival Resident Prival Residence of Prival Residence | de Facility Name (if not institution, give street and number) Genesis Eldercare Harmonds Lane Social Security Number 2 9 310 1 M 28F 7, Age fin yrs. set birtholey) 1 Moder 1 Year I Worder 2 Ha. R. Date of Birth (incher), Days 1 Moder 1 Year I Worder 2 Ha. R. Date of Birtholey 2 19 22 9310 1 M 28F 7, Age fin yrs. set birtholey) 1 Modern 1 Days 1 Modern 1 Min. 1 Martial Status 1 Dic. City, Town or Location Baltimore 10c. Street and Number 6 13 Harmonds Lane 1 Was Decodered of Hispanic Origin? (Specify Year or North Year) 1 Martial Status 1 Martial Status 1 New Married 1 Martial Status 1 New Married 1 Martial Status 1 New Married 1 New M | ## Facility Name (if not institution, give stress and numbers) Genesis Eldercare Hammonds Lane Social Social Sociality Number 2.19 22 9310 Usual Residence of Decaders 10 C. Cay, Town or Location Baltimore 10c. Stress 10d. 287 8 85 7 nn. 10c. Chy, Town or Location Baltimore 10c. Chy, Town or Location Baltimore 10c. Stress 10d. Cay Town or Location 10c. Stress 10d. Cay Town or Location 10d. Cay Town March Stress 10d. Cay Town Stress 10d. | 46 Facility Name (If not institution, give diment and number) Genesis Eldercare Harmonds Iane Social Social Social Plant (Inc.) 100 Care (Inc.) 110 AND F Ray (Inc.) was at formidally and the Care (Inc.) 110 AND F Ray (Inc.) was at formidally and the Care (Inc.) 111 And Inc.) 112 Inc. Care (Inc.) 113 Harmonds Iane 114 Was Decoders (Inc.) 115 Decoders (Elevation) 115 Decoders (Elevation) 116 Notes (Inc.) 117 Facility Name (Inc.) 117 Facility Name (Inc.) 118 Medital Salus 118 Work (Inc.) 119 Name (Inc.) 119 Decoders (Inc.) 110 Decoders (Inc.) 110 Decoders (Inc.) 110 Decoders (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 111 Nove Decoders (Inc.) 112 Was Decoders (Inc.) 113 Harmonds Jane 110 Nove Married (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 110 Nove Married (Inc.) 111 March Salus 111 Nove Decoders (Inc.) 112 Nove Decoders (Inc.) 113 Nove Decoders (Inc.) 114 Nove Decoders (Inc.) 115 Nove Married (Inc.) 116 Nove Married (Inc.) 117 Nove Decoders (Inc.) 118 Nove Married (Inc.) 119 Nove Married (Inc.) 110 Nove | |



Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at ends.

Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit.

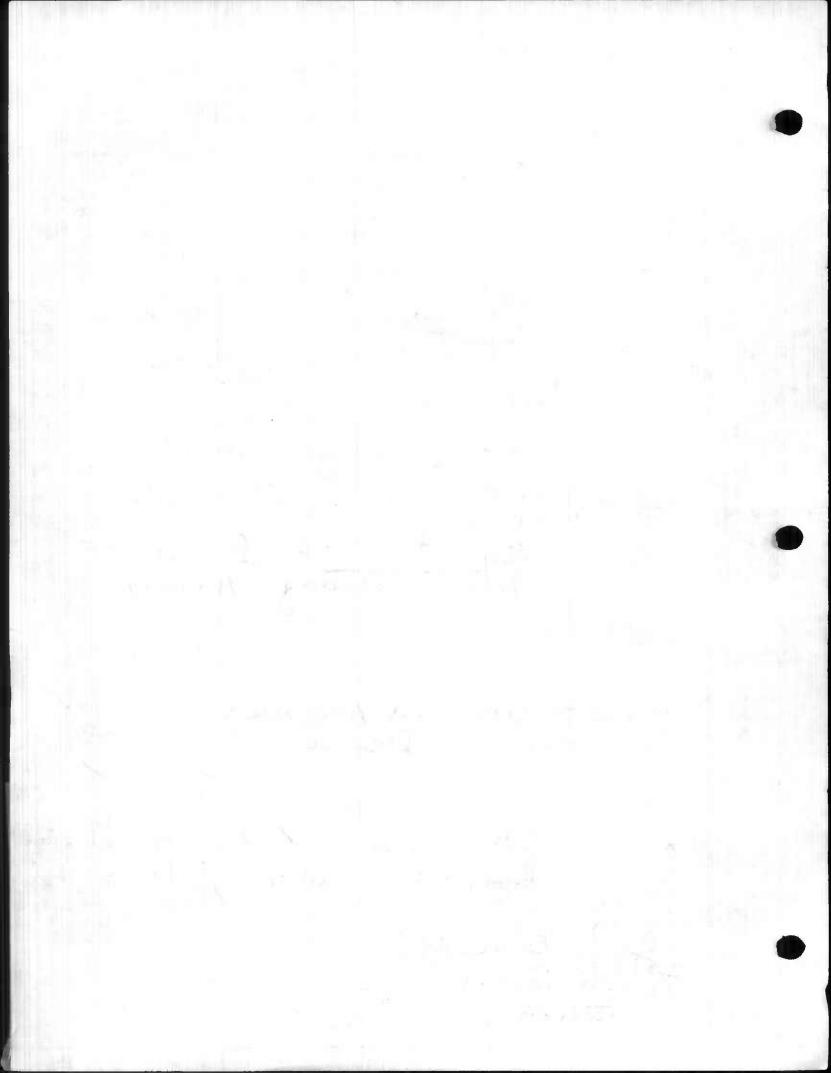
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| K | | | State of M | laryland / | | artment | | | and M | lental Hygi | ene g. No. | 00 | 040 | 03 |
|------------------|---|-----------------------|----------------------------------|------------------------------------|---------------------------|---------------------------------------|-------------------|---------------------|------------|--------------------------------------|---------------|--------------------------|---|------------|
| | 1. Decedent's Name (/ | First, Middle, Le | st) | | | | | | | 2. Dete of Death | | Maria | 3. Time o | t Deeth |
| n | THELMA | | | | COOL | 7 | | | 7. | Month FEBRUAR | Y 7, | 2000 | 9:00 | PM |
| il r | 4a Facility Name (If no | r) | LUUI | | 4 | b. City, To | wn, or Lo | cation of Death | 4c. Cou | nty of Death | | | | |
| | MARYLAND | GENERA | AL HOSPITA | AL. | | | | BALT | IMOR | E | | N/A | | |
| ř | 5. Social Security Num | | | ge (in yrs. last i | birthday) | If Under | | If Under | | 8. Dete of Birth | Vacel | 9 Birth | place (State | or Foreign |
| | 220 36 88 | | 1□M 2 F | 58 | Yrs. | Months | Days | Hours | Min. | (Month, Day, 3/12/4) | | MD | ntry) | |
| | Usual Residence of De | ecedent | | | | | | | | | | | | |
| | 10a. Steta 10 | 0b. County | | 10c. City, To | wn or Lo | cation | | | | | | | 10d. tnside C | |
| 010 | MD | | N/A | | BALT | IMORE | | | | | | | 1 🔼 Yes | 2 No |
| runeral Director | 10e. Street and Number | er. | | | | 10f. Zip | Code | | | 10 | g. Citizen | of What Cou | ntry? | |
| 3 | 530 SANFO | RD PLAC | E | | | | 212 | 17 | | | USA | | | |
| i e | 11. Meritel Stetus | | 12. Wes Decedent Armed Forces | t Ever in U,S. | 13. V | Ves Deced | ent of Hi | spanic Ori | gin? (Spe | ecify Yes or No- Rican, etc.) | | tace - Ameri | | |
| | 1 Never Merried | 2 Married | 1 Yes 2 | | | Yes 2 | | Specify: | , 1 00.10 | , mount, oto., | | | | |
| 9 | 3 ☐ Widowed 4 ☐ | Divorced | Year or Detes | : | | 100 2 | 27,40 | эрвину. | | | Spe | city:BLAC | K | |
| Completed by | | . Decedent'a E | ducation ade completed) | 16 | a. Deced | lent's Usua kind of wor | l Occupi | ation furing mos | t of worki | | 6b. Kind of | Business/In | dustry | |
| d l | Elementary/Seconds | | College (1-4or | 5+) | life. E | DO NOT us | e retired |) | | | HOM | R | | |
| 5 | , | | | | HUI | USEKE | EPEK | | | | HOM: | L | | |
| 0 | 17. Father's Name (Fir. | | | | | | | | | (First, Middle, M EEN SNEEL | | ame) | | |
| 0 | HARRY | RANDA | T-1- | | | | | N.F | TIULL | EEN SNEE | , | | | |
| | 19a. Intormant'a Neme | /Reletionship (| Type, Print) | 15 | 9b. Meilin | g Addrass | (Street a | and Numbe | er or Rura | al Route Number, | City or To | wn, State, Zij | p Code) | |
| | HARRISON | COOK | | | | SANFO | | LACE | BAI | TIMORE, | MD. | 21217 | | |
| | 20a. Method of Disposi 1 ABurial 2 C 4 Donation 5 [| remation 3 [| Removel from Stete | 20b. Place ceme CR | tery, crem | sition (Name natory or of VILLE | her plac | · CEN | 1 2, | Date 2 /14/2000 | | n - City or To NSVILI | | |
| | 21. Signeture of Funer | | | | | . Name end | | | | | | | | |
| | (man | 1 - Q | mant | im a | | | | | | SONS F.H | | | | |
| _ | 23a. Part J. Enter the c | UC 00 911 | min | d the death D | | | | | | BALTO. | | 21217 | Approxime | 4.0 |
| H LABITURE | Immediata Cause (Fin disease or condition resulting In daath) Sequentially list condit if any, leading to imme cause. Entar Underlyit Cause (Disease or Inju | clons, addiete | . Asy | Buo to (or as | tie O de e conseque | CCL uence of): | ud | DF line | } | Bol | us w | ey! | F | |
| - Inches | that initiated events resulting in death) Last | | d | Due to (or es | consequ | uence of): | | | | | | | | |
| i | | | J | | | | | | | | | | | |
| 100 | Part II. Other aignificat | nt conditions o | ontributing to death | but not resulting | in the un | derlying ca | usa give | en in Part t | 101 | 23b. Did tol | DACCO USO | contribute t | to the cause | of death? |
| | Hyp | este | ensive | · a | nd | 1 | tth | erosc | ereti | C 10 Ye | 8 2 N | o 3 Pro | obably 4 🖸 | Unknown |
| POLON | Caro | diov | ascul | lar | D | Sise | eas | se. | | 24a. Wes ar perform | | 8/ | ere autopay vallable prior empletion of death? | to |
| 5 | | | | | | | | | | 1010 | s 2 No | | PYas 2 |] No |
| | 25. Was case reterred | to medical | | | | | | 00.5 | of Door | ,,,,,, | | 1 | LTTAS 2L | 1 MO |
| 5 | exeminer? | O medical | Hospitel: | | Suda et e | | Othe | No. | | Check only one | | Data and All | 4.1 | |
| | 27. Manner of Deeth | | 1 L Inpat | ient 2 ER/0 | Outpatient Time of | | ^ | 4LJ NU | | me 5 Resider 28d. Describe ho | | | ry) | ^ |
| 2 | 1 Natural 5 | Panding Investigation | (Month D | | injury | | Bc. Injun Work | (? Yes 2 | | 9.1. | 10 | 16 | ad | Food |
| | 2 X Accident 3 ☐ Suicide | Could not b | 0-11 | hiury - At home | | WW lectory | | | | 28f. Location (Str | eet and Nu | mber or Rur | ral Boute Nur | nher |
| | 4 Homloida | determined | bd iding, e | njury - At home, itc. (Specify) | A CO | < | 0 | 0 | QI | 28f. Location (Str. City or Yourg | Stete | -1)00 | 00 | n 0 |
| | 29a. Cartifier 1 | Cartifulan Di | ysictan: To the best | of my knowled | no doot | 2000 | 170 | rac | V 19 | ce) | 2 | Jane | 110 | 1 Ich |
| | | Medicat Exer | niner: On the basis and menner s | of examinetion a | and/or inv | restigation, | in my of | oinion, dea | th occurr | ed et tha time, da | ta and plac | e, and due t | to the cause(| s) |
| | 29b. Signature and title | of certifier | 4 | | | 29c | License | number | | 20 | d. Date sin | ned (Month | Day, Year) | |
| i | | Par | 10. | 1 | 1 1 | \ | | C.M. | E. | | | | , 2000 | |
| | 20 11- | The same | - www | ٧,١٧ | [-L |). | | | | | | | | |
| | 30. Name and address | of person who | 1 7 2 | | | | | D=2.1 | · | a Ma - 7 | | 1201 | | |
| | 31. Date III 5d (Month, I | L.V. | | | renn | STIE | et, | Balt | шюг | e, Maryl | and 2 | 1201 | | |
| | | FEB 1 (| 2000 N | race Signeture | 1 | 9 | 100 | char |) | | | | | |
| | | PU + | COUG F | | 1 | - | A | - 60 | | | | | | |

State Registrar



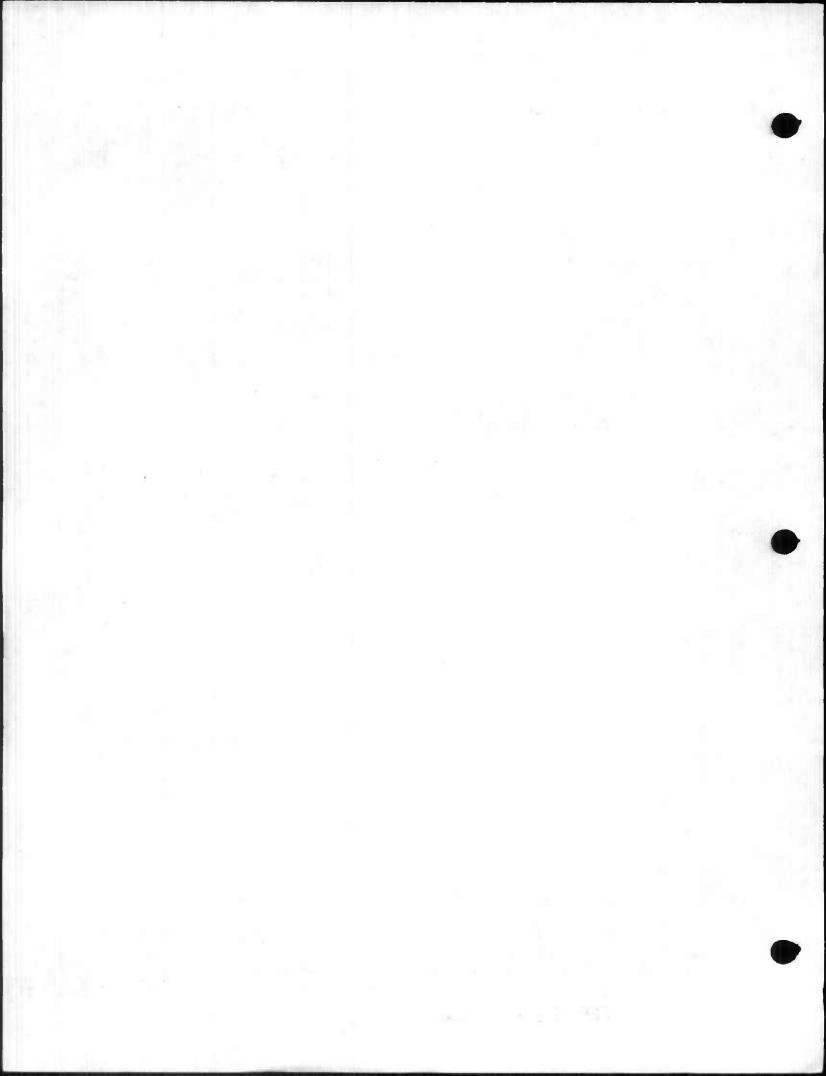
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State of Maryland / Department of Health and Mental Hygiene

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|---|---|---|---|---|---|-----|
| | | | | - | - | - 8 |

| 4b. City, Town, or TOWSOT | 8. Dete of Birth (Month, Dey, Year) September 16, 190 10g. Citizen of United S Specify Yes or Noto Rican, etc.) 14. Re Ble Specify S | 9. Birthplace (State or Foreign Country) Dayton, Chio 10d. Inside City Limit 1 Yes 2 N Whet Country? tates of America sec, White, etc. | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| TOWSON birthdey) If Under 1 Year If Under 24 Hrs Months Deys Hours Min. fown or Location 10f. Zip Code 21234–3713 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify: | February 08, 200 Location of Deeth 4c. Count September 16, 190 September 16, 190 Injury 10g. Citizen of United Sepecify Yes or Note 14. Reside Rican, etc.) | 3:30 A.M. y of Death altimore Co. 9. Birthplace (State or Foreign Country) Dayton, Ohio 10d. Inside City Limit 1 Yes 2 N Whet Country? tates of America sec, White, etc. | | | | | | | |
| TOWSON birthdey) If Under 1 Year If Under 24 Hrs Months Deys Hours Min. fown or Location 10f. Zip Code 21234–3713 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify: | 8. Dete of Birth (Month, Dey, Year) September 16, 190 10g. Citizen of United S Specify Yes or Noto Rican, etc.) 14. Re Ble Specify S | 9. Birthplace (State or Foreign Country) 9. Dayton, Ohio 10d. Inside City Limit 1 Yes 2 N Whet Country? tates of America 10d. America Indien, eck, White, etc. | | | | | | | |
| birthdey) Yrs. If Under 1 Year If Under 24 Hrs Months Deys Hours Min. | 8. Dete of Birth (Month, Dey, Year) September 16,190 10g. Citizen of United Sepecify Yes or Note Rican, etc.) 14. Respecify Specific Spe | 9. Birthplace (State or Forei Country) Dayton, Chio 10d. Inside City Limi 1 Yes 2 N Whet Country? tates of America ice - American Indien, eck, White, etc. | | | | | | | |
| Months Deys Hours Min. Town or Location Tof. Zip Code 21234–3713 13. Wes Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify: 6a. Decedent's Usuel Occupation | Month, Dey, Year) September 16, 190 10g. Citizen of United S Specify Yes or No- to Rican, etc.) 14. Re Ble Specify Specify Yes or No- to Rican, etc.) | Dayton, Ohio 10d. Inside City Limi 1 □ Yes 2 N Whet Country? tates of America coe - American Indien, ack, White, etc. | | | | | | | |
| imore 10f. Zip Code 21234–3713 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🖄 No Specify: 6a. Decedent's Usuel Occupation | United S Specify Yes or No- to Rican, etc.) 14. Re Ble Specify Specif | 1 ☐ Yes 2 ☑ N Whet Country? tates of America coe - American Indien, eck, White, etc. | | | | | | | |
| imore 10f. Zip Code 21234–3713 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🖄 No Specify: 6a. Decedent's Usuel Occupation | United S Specify Yes or No- to Rican, etc.) 14. Re Ble Specify Specif | 1 □ Yes 2 N Whet Country? tates of America coe - American Indien, eck, White, etc. | | | | | | | |
| 21234–3713 13. Wes Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerl | United S Specify Yes or No- to Rican, etc.) 14. Re Ble Specify Specif | tates of America oce - American Indien, eck, White, etc. | | | | | | | |
| 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 Yes 2 No Specify: 6a. Decedent's Usuel Occupation | Specify Yes or No- to Rican, etc.) 14. Re Ble Speci | ce - American Indien, eck, White, etc. | | | | | | | |
| 1 ☐ Yes 2 🗹 No Specify: | to Rican, etc.) Ble | eck, White, etc. | | | | | | | |
| Decedent's Usuel Occupation (Give kind of work done during most of wollife. DO NOT use ratired) | 16h Vind of S | w. White | | | | | | | |
| 'life. DO NOT use ratired) | rking | Business/Industry | | | | | | | |
| | | | | | | | | | |
| Aircraft Mechanic | | L. Martins | | | | | | | |
| 18. Mother's Ne | me (First, Middle, Maiden Sume | me/ | | | | | | | |
| Lucy Cora | Varney | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | - City or Town, State | | | | | | | |
| 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Hilltop Service Corporation 02/09/2000 Towson, | | | | | | | | | |
| | | | | | | | | | |
| 1050 York Rd. Towson, Md. 21204 | | | | | | | | | |
| | | | | | | | | | |
| | C2h Did tehana usa s | ontribute to the course of de- | | | | | | | |
| ng in the underlying couse given in Paπ I. | - ALL | 23b. Did tobacco use contributs to the cause of deal 1 Yes 2 No 3 Probably 45 Unkn | | | | | | | |
| | | Oth Man subsectioning | | | | | | | |
| | performed? | 24b. Were autopsy tinding available prior to completion of cause of death? | | | | | | | |
| | 1 Yes 2500 | 1 Yes 2 10 | | | | | | | |
| 26. Place of De | eath (Check only one) | | | | | | | | |
| VOutpatient 3 DOA Other: 4 Nursing | Home 5 ☐ Residence 6 ☐ O | ther (Specify) | | | | | | | |
| Bb. Time of lnjury et Work? M 1 Yes 2 No | 28d. Describe how injury occ | urred | | | | | | | |
| M 10165 20140 | | | | | | | | | |
| e, farm, street, fectory, office | 28f. Location (Street and Nun City or Town, Stete) | nber or Rural Route Number, | | | | | | | |
| | e, end due to the cause(s) and r | menner as stated. | | | | | | | |
| e, farm, street, fectory, office | e, end due to the cause(s) and rurred at the time, date end place | menner as stated. | | | | | | | |
| e, farm, street, fectory, office dge, death occurred et the time, date and plec and/or investigation, in my opinion, deeth occ | e, end due to the cause(s) and rurred at the time, date end place | menner as stated. e, and due to the cause(s) | | | | | | | |
| e, farm, street, fectory, office dge, death occurred et the time, date and plec and/or investigation, in my opinion, deeth occ | e, end due to the cause(s) and rurred at the time, date end place | menner as stated. e, and due to the cause(s) | | | | | | | |
| | Lucy Cora 19b. Mailing Address (Street and Number or R 8510 Willow Oak Road Bal e of Disposition (Neme of etery, crematory or other piece) COP Service Corporation 22. Name end Address of Fecility Ruc 105 Do not enter the mode of dying, such as cerdia 3 consequence of): 3 e consequence of): 26. Place of De Woutpatient 3 DOA Other: 42 Nursing | Lucy Cora Varney 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town 8510 Willow Oak Road Baltimore, M. 21234— e of Disposition (Neme of etery, crematory or other place) COP Service Corporation | | | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Hark anes 4:36 2000 4e. Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth 4c. County of Deeth Te dical System a Mary kuc UNI CERSITY O 265 y/huo times If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 10M 20 F Months Deys Hours Min. 14-54-634 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nos 2 No timore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21 454 orth Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry acific Elementery/Secondary (0-12) College (1-4or 5+) 11 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) lark 451 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9/256 19e. Informent's Neme/Reletionship (Type, Print) thea Ba timore 10 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Neme end Addrese of Facility funeral home Services 1639 2/3 23a. Part / Entire the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest Approximete intervei Between Onset end Deeth fmmediete Ceuse (Finei diseese or condition resulting in death) Due to (or es a consequence of) Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 30 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 Yes 28. Piece of Deeth (Check only one)

Physician /Medical Examiner

nding physician end use as the burial-tran

signed by the attending I be detached for use as

peen has

this certificate

funeral director,

Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifice

To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th

à

Completed

Be

Certification: To

edical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

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Funeral

Director

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last Physiclan/Medical

> 25. Wes case referred to medical examiner? 20 No 1 Yes 27. Manner of Death

5 Pending investigation

6 Could not be determined

Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28h Time of

3□ DOA

28c. fnjury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

29a. Certifier

1 Neturel 2 Accident

3 Suicide

4 - Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

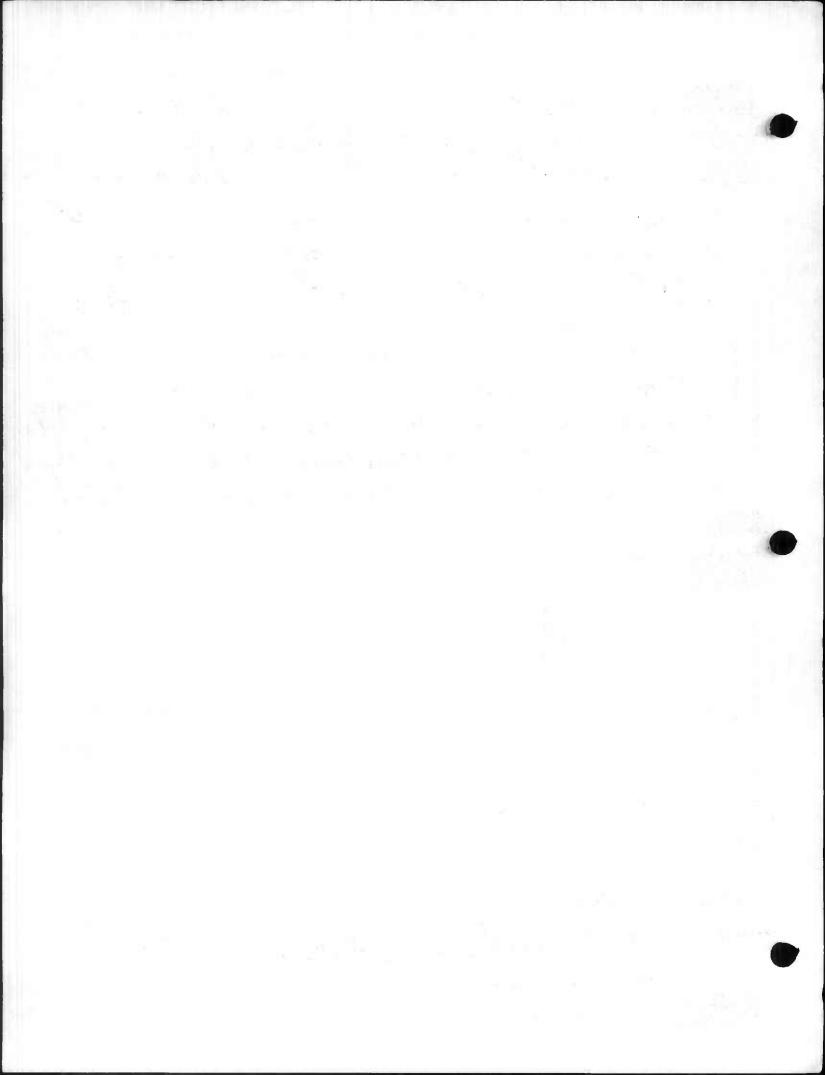
30. Nemerend eddress of person who comp eted cause of deeth (Item 23a) (Type, Print) eeke

2000

31. Dete filed (Month, Dey, Year) FEB 10

32. Registrar's Signeture Sepura

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death **Physician** Month Yaar 2000 February pM /Medical 4a. Fecility Nema (If not institution, give street and number) 4h City Town or Location of Deeth 4c. County of Death Examiner GoodSamaritan If Under 1 Yeer If Undar 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sax **Funeral** 1□ M 201 Days Yrs. Director 42822805 Feb. 15, 1918 Mississippi Usual Rasidence of Decedant death with the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore Was 2□No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "natural", or items 23a or 912 E. 43rd Street 21212 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ Ne If Yas, Giva Yeer or Detas: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status filed within 72 hours after 1 Nevar Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Completed by 3 ™idowed 4 □ Divorced 15. Decadant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Private Duty Department of Haaith and Mental Hygiena. Important: If Item 27 Ia marked other than eny injury or other traumatic event, the Ma Elamantary/Secondary (0-12) Collaga (1-4or 5+) Nurse/Teacher Balto. City Pub. Sch. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Haalth and Mental I William Lindsey Elouise Cooper 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) William Cox, Sr. son 912 E. 43rd Street Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1) urial 2 Cramation 3 Ramoval from Stata Baltimore Cemetery Feb. 11 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvige Hou 22. Name and Addrass of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Final 45 Wyocard: W disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner tha burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Lest Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of) 88 signed by the eight P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No (DAT Records, by paga 2 should 24b. Wara autopsy findings evailable prior to Completed 24a. Was an autopsy CVA complation of cause of daeth? 2 14 No 1 Yas cartificata of Vital or Attending Physician: director. Be 25. Was cesa refarrad to medicel axaminar? 26. Placa of Daath (Check only one) Hospital: 1 | Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 R/Outpatient 3 DOA Certification: To this the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. fnjury at Work? 28d. Describe how Injury occurred : Aftar Division 5 Panding invastigation 1 Natural 2 No To the Hospital or Attendi within 24 hours aftar daath. To the Funeral Director: A 2 Accidant 6 Could not ba 3 Sulcida in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida filled 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical complataly (Check only one) 29b. Signatura and title of certifian 29c. Licensa numbar 29d. Data signed (Month, Day, Year) 2 1 3 100 30. Name and addrass of parson who complated ceusa of death (Itam 23a) (Type, Print) 560160ch Raven Blvd Michard encer

Registrar

DHMH 16 Rev 6/95

State

31. Data filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** CARTER OTTIE EB. 2000 9:38 AM 08 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE
If Under 24 Hrs.
Hours Min.

B. Date of Birth
(Month, Day, Year)
DEC. 22, 1902 CENTER GREEN NURSING 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 217-22-6744 Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Director ALTIMORE 288-1 MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 14. Race - American Indian, Black, White, etc. 2 / 2 / 6

13. Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 23s VNER AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3.⊠ Widowed 4 □ Divorced BLACK Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If itam 27 is marked other that any injury or other traumatic avant, train place. 10 THGRADE THERAPIST HENDRINSON HOSPITAL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be OGAN MARU CUNNING HAM 10 VAN LANDINGHAM 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203, 6510 EBERLE DR ALVERTA H. WRIGHT (DAUGHTER) BALTIMORE, MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS CEMETERY 82-12-00 BALTIMORE, MARKAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses BROWN JR. FUNERAL HOME 2140 N. FULTONAVE. BALTIMORE, MD. 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ehook, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Vareula desease Examiner mellitu Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 □ Yes 2 □ No signed t Records. Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 PINO 1□ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident To the Hospital or Attanovithin 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. D054636 10,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar UL

31. Date filed (Month, Day, Year) FEB 1 0 2000

SYED

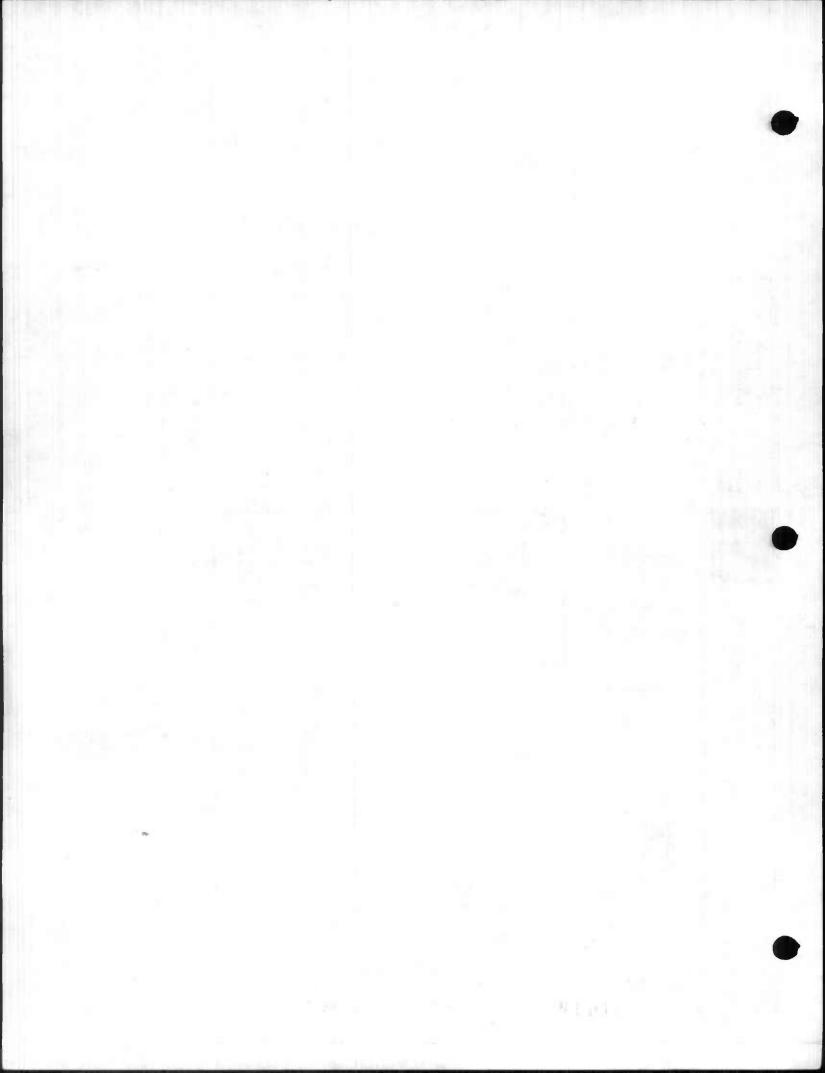
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EUTAW ST. #36 BALTO, MD 21201

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32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** CEVIS February 8, 2000 n of Death 4c. County of Death JOHN WILLIAM 2000 9:55 AM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Perry Point
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) VA Maryland Health Care System 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 180M 2□ F Yrs 75 Director 220-12-9452 December 28 1924 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Experient Hust be notified at 1 Yes 20No Director MARYLAND HARFORD STREET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 1524 ARENA ROAD death v Funeral 21154 12. Was Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after nd Mental Hygiena. 1 Nevar Marriad 2 Married 1 ØYes 2 ☐ No If Yes, Giva Maryland 21215-0020 1 日 YasX 五日 No Specify: by it Yes, Giva Year or Dates: BLACK 3 Widowed 4 Divorced 43/46 Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed will Department of Haalth and Mental Hygien Important: If item 27 is marked other tru any fulury or other treatmetic event, the other. APG EDGEWOOD 8th/GED CHEM LAB TECH 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN W. CEVIS, SR. 0 MARY ETHEL CEVIS 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna E. Cevis/Wife 1524 Arena Road, Street, Maryland 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date ₩Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JAMES U.A.M.E CHURCH | 2-12-00 DARLINGTON, MARYLAND 24. Signature of Juneral Service Licens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA-ABERDEEN Part1. Enter the disease, or won shock, or heart failure. List only 321 S. PHILADELPHIA BLVD cations that caused the death. Do not anter the mode of dylng, such as cardiac or raspiratory arrest, to cause on each line. Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Amyotrophic Lateral Sclerosis, Terminal 16 Years Examiner Due to (or es a consequence of) Physician/Medical Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tha attanding physician hed for use as tha buria Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

signed by the a peen

TO PHYSICIAN

CEVIS

WILLIAM JOHN

NAME KNOWN

The law requires that the death certificate be asscuted cartificata has or Attending Physician: this funaral Aftar death. 24 hours after death Funeral Director:

þ

Completed

Be

2

Certification:

edical

filled in

Hospital

within 2

Division of Vital Records,

Probable Septicemia

24a. Wes an autopsy Diabetes Mellitus

Hypertension 25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 1 Matural 5 Pending invastigation 2 Accident 6 Could not be determined 3 Suicide

28a. Date of Injury (Month, Day Year) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 8 Other (Specify) 28b. Time of 28c. Injury at Work?

28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 No

(Check only one) 29b. Signature and title of certifier,

29a. Certifie

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

Mucy

151094-1

February 8, 2000

24b. Were autopsy findings available prior to completion of causa of death?

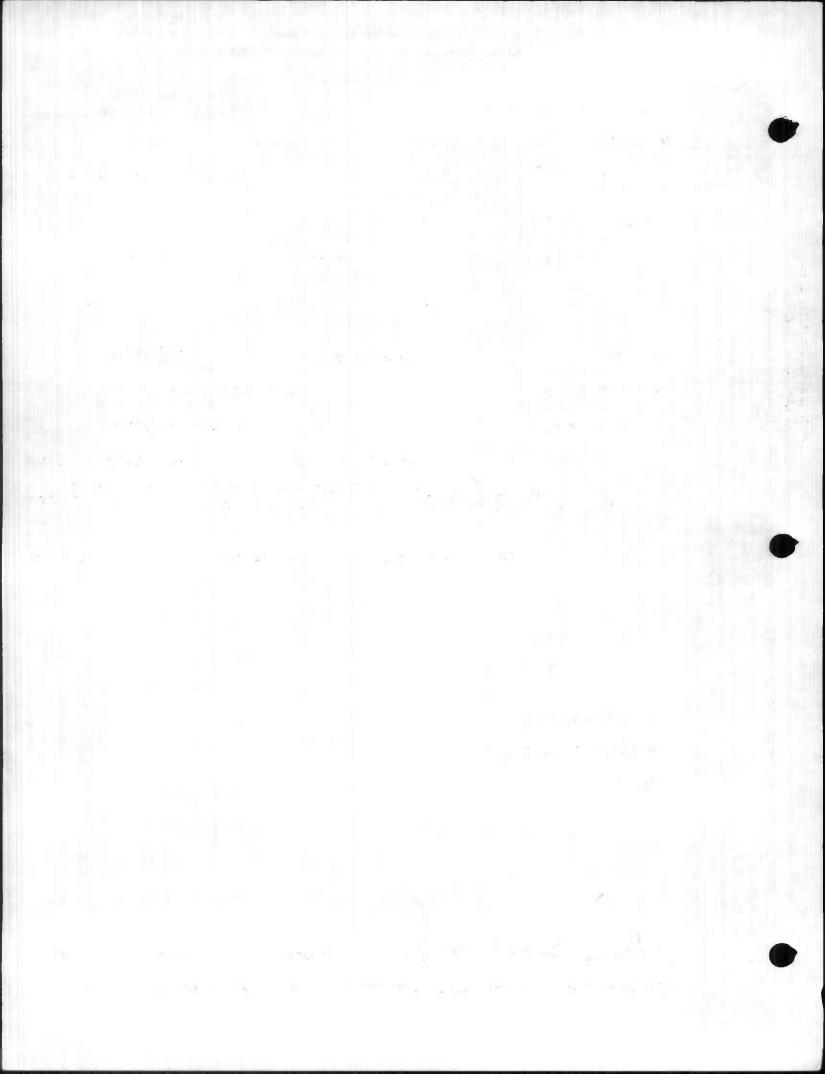
1 TYes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELECIA SANTOS, M.D., 31. Date filed (Month, Day, Year)

VA Maryland Health Care System, Perry Point, MD 21902 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** William W. Calary, Jr. February 2000 10 am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1942 Mountain Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □XXX 2 □ F Months Days Hours Yre 218-22-7407 73 **Director** MD Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Baltimore Baltimore Directo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zlo Code permit, Pages 1 and 2 should be filed within 72 hours effer deeth v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a
page lijury or other traumatic event, the Med 1942 Mountain Avenue Funeral 21234 USA 12. Was Decedent Ever in U,S.
Armed Forces?

1 DX'es 2 □ No
H Yes, Give
Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Tes 2 No Specify: altimore, Maryland 21215-0020 g 3 ☐ Widowed 4 ☒Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Mechanic University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William W. Calary, Sr. Margaret Sophia (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Junming Yang - Power of Attny. 2818 Aspen Hill Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2000 Chesapeake Crematory Beltsville, MD 22 Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Drive, Towson, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 days Urosepsis Examiner Due to (or es e consequence of): Examiner Polyneuropathy attending physician and for use as the buriel-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): (probable) Gall Bladder Cancer Physician/Medical USB as ! signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this 28e. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end manner as stated.

2 Madical Examinar: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 To the 29b. Signature and and certifier 29c. License number 29d. Date signed (Month, Day, Year) amma Mo D0054634

February 8, 2000

4940 Eastern Ave., Baltimore, MD

backs

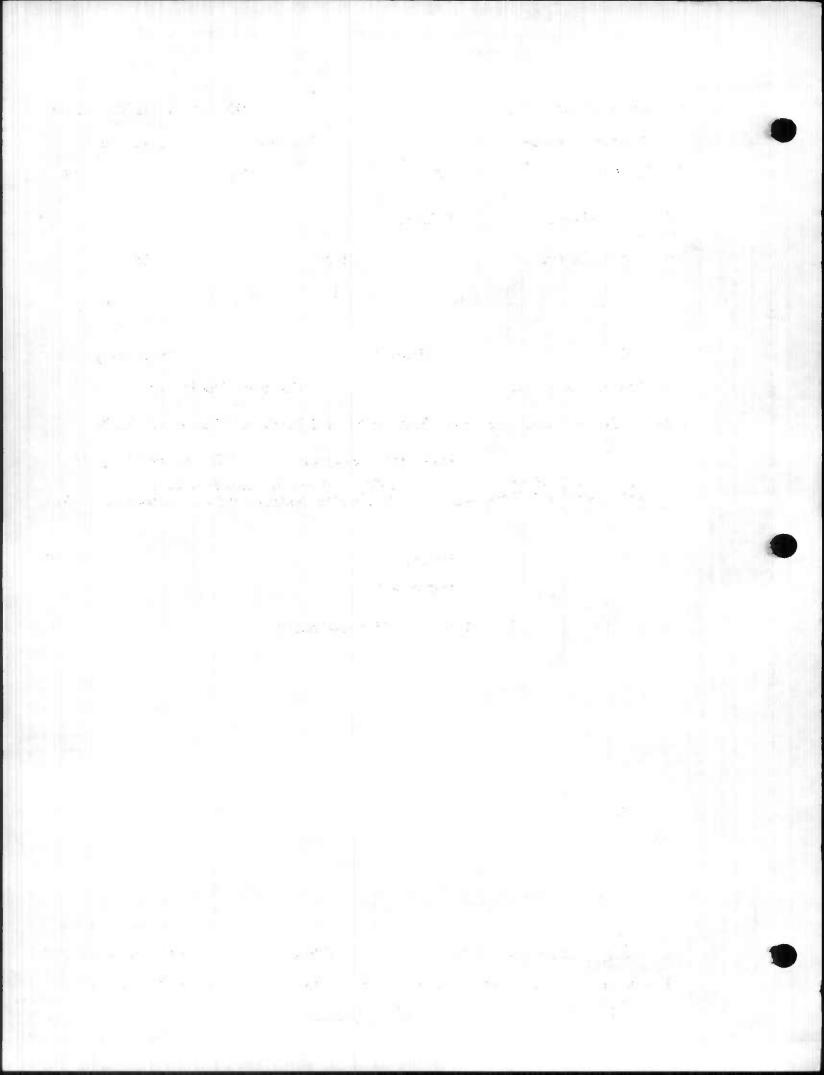
State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Hospital,

32. Registrar's Signature

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate o | f Death | | leg. No. | 04010 | | |
|--|---|--|--|---|-----------------------------------|--|--|--|--|
| Physician | 1. Decedent's Neme (First, Middle, L. | nst) | | | 2. Dete of Dea Month | th Dey | 3. Tima of Death | | |
| /Medical | Gretchen | Louise | Collins | Collins | | | 000 4:40 PM | | |
| Examiner | 4a Facility Name (If not institution, gi | ve street and number) | | 4b. City, Town, or L. | ocation of Death | 4c. County | of Death | | |
| | Devlin Manor | Nursing Home | | Cumber | land | Alle | CONT | | |
| Funeral | | | rs. last birthday) If Under 1 Ye | ar If Under 24 Hrs. | 8. Dete of Birth | ATTE | Birthplace (State or Foreign Country) | | |
| Director | 215-05-9392 Usual Residence of Decedent | 1□M 2\(\overline{\text{V}}\)F 89 | Yrs. Months Day | ys Hours Min. | Nov. 4, | 1910 | Maryland | | |
| A SH | 10a. State 10b. County | 10c. | City, Town or Location | | | | 10d. Inside City Limits | | |
| or zha-f sh be notified. Director | MD Baltimore Catonsville | | | | | | | | |
| 23s or 2 ust be n | 120 Smithwood A | venue | 10f. Zip Code 21: | 228 | 1 | 10g. Citizen of What Country? U.S.A. | | | |
| 2 hours after death visituals, or here 23sted Examiner must | 11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 13. Wes Decedent of if Yes, specify C | f Hispanic Origin? (Spuban, Mexican, Puerto lo <i>Specify:</i> | pecify Yes or No- Rican, etc.) | No- 14. Race - American Indien, Black, White, etc. Specify: White | | | |
| | 15. Decedent's E (Specify only highest gr | ducation | 16a. Decedent's Usual Occ | cupation | ring | 16b. Kind of Bu | siness/Industry | | |
| rt, the Medical | Elementary/Secondary (0-12) | College (1-4or 5+) | | ne during most of work ired) | ang . | | | | |
| | 1.4 | | Bookkeeper | 40.14.0.4.15.0 | - (Final Adiabat) | Groce | | | |
| Be ed | 17. Father's Name (First, Middle, Last Frederick C. Di | • | | 18. Mother's Nam | | | 9) | | |
| To | | | | | t Hanite | | | | |
| 5 | 19a. Informant's Neme/Relationship | (Type, Print) | 19b. Mailing Address (Stre | | | | | | |
| 1 | Joseph Collins | (son) | 14301 Hardmo | n Road, S. F | Cumber | rland. N | ID 21502 | | |
| and | 20a. Method of Disposition 1 | Removal from State | cometery, crematory or other p | HECE) | | | | | |
| 10 | 4 Donation 5 Other (Speci | Theilioval Itolii State | St. John's Ceme | etery 2 | 2/8/00 | Ellicot | t City, MD 2104 | | |
| を一般 | 21. Signeture of Fuperal Service Lice | nsee | 22. Name and Add | dress of Facility Wi | tzke Fu | neral H | ome, Inc. | | |
| E | Michael | 1 mure | 1630 Edn | | | | le, MD 21228 | | |
| | 23a. Part1. Enter the disease, or con shock, or heart feilure. List only | oplications that coused the d | eath. Do not enter the mode of o | tying, such es cardiac | or raspiretory err | ast, | Approximate Interval Between | | |
| cian | aroon, or mount rollare. List only | One Cause Oil becil mie. | | | | | Onset end Deeth | | |
| dical | tmmediete Cause (Final | 1 | - 0 | | | | 7 > 40 - | | |
| niner | disease or condition resulting in death) a. ACUTE RENAL FAILURE 3 D. Due to (or as a consequence of): | | | | | | | | |
| | | | | | | | | | |
| the bune-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| X | | | | | | | | | |
| | Cause (Disease or injury | c | | | | | | | |
| edical | resulting in death) Last | Due to | (or as a consequence of): | | | | | | |
| Š | - 1 /2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | d | | | | | | | |
| - | | | | | | | | | |
| Physician/M | Part II. Other significant conditions | contributing to death but not | resulting in the underlying cause | given in Pert t. | 23b. Dld to | obacco uae cor | tribute to the cause of death? | | |
| F | LARGE DI | LODENAL | IIICER | | 1 🗆 Y | ea 2 PNo | 3 Probably 4 Unknown | | |
| should be detached for use a leted by Physician/Me | | | | | 24a. Was a | a autora | 24b. Wera autopsy findings | | |
| Completed by | ANAEMIA | 20 Ta | SASTROINTESTIO | VAL- | 24a. Was a perfor | | evailable prior to completion of cause | | |
| director, page 2 s o Be Comple | , | | The state of the s | | | | of death? | | |
| 00 | BLOOD | Loss | | | 1 U Y | es 2 No | 1 ☐ Yes 2 Ø No | | |
| Be | 25. Was case referred to medical axaminer? | | | 26. Place of Deal | th (Check only or | na) | | | |
| - | 1 Yes 2 No | Hospitat: | ER/Outpatient 3 DOA | Other: 4 Nursing Ho | ome 5 Reside | ence 6 Othe | er (Specify) | | |
| | 27. Manner of Death | 28a. Date of Injury (Month, Day Year | 28b. Time of 28c. Ir | | 28d. Describe h | | | | |
| completely filled in by the funeral Medical Certification: 1 | 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation | | | Yes 2 No | | | | | |
| Certification: | 3 ☐ Suicide 6 ☐ Could not b | 288. Place of Injury - A | t home, ferm, street, fectory, offic | > | 28f. Location (S | treet and Numb | er or Rural Routa Number, | | |
| T | 4 Homicide | building, etc. (Spe | ecity) | | City or Town | n, Stete) | | | |
| <u>=</u> | 29e. Certifier 1 Certifying Pl | nysician: To the best of my i | cnowledge, death occurred at the | time, data and place. | end due to the c | ausa(s) and ma | nner as stated. | | |
| completely filled in Medical Cert | (Check only 2 Medical Examone) | miner: On the basis of exam and manner stated. | ination and/or investigation, in m | y opinion, daath occur | red at tha tima, d | lata and place, a | and dua to the causa(s) | | |
| N N | 29b. Signeture and title of certifier | 1- 0 | 29c. Lice | ense number | 2 | 9d. Date signed | (Month, Day, Year) | | |
| | | E38W | MX. D | 23334 | T | EBRUAR | 5 TH 2000 . | | |
| | 20 Neme and address -1 | completed Sur 1167 f | | -3337 | | - 1016 | | | |
| | 30. Name and address of person who | | | 1 W1 015 | 0.0 | | | | |
| | Dinesh Shah, M.D | | Ave. Cumberland | | JZ | | | | |
| State | 31. Date filed (Month, Day, Year) FEB 1 0 20 | 00 September 33 | mature & space | is . | | | | | |
| Registrar - | | // | / // | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 07,2000 **Physician** Evonne Davis 12:30 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing and Rehabilitation Ctr. Baltimore N/A If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year)
April 1, 1956

8. Birthplece (State or Ford Country)
Pennsylvania 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days 10 M 3 Hours 257-13-0550 43 Director **Usual Residence of Decedent** the Meryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter deeth with 1 and of Heelih and Meriel hygiene.
Art. If Nem 27 is marked other than natural, or Nema 23a or inty or other traumed event, reserved. 2525 West Belvedere Avenue 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married Specify: Black Baitimore, Maryland 21215-0020 1 Yes WNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 4 College (1-4or 5+) Counselor Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 George Davis Bertha Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn B. Gibson (Mother) 4920 Greenspring Ave. Balto., Md. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Depertment of Important: If eny Injury or phos. 2/10/2000 Landsdowne, Maryland Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licenses 5502 Winner Ave. Balto., Md. 21215 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** HUNTINGTON'S CHORZA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 000 P.O. Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yas 2 No 3 Probably Wunknown Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∏Yes 2D No 1 Inpatient 2 ER/Outpatient 3 DOA shie After this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours effect death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 52360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 312 CREENE

State Registrar

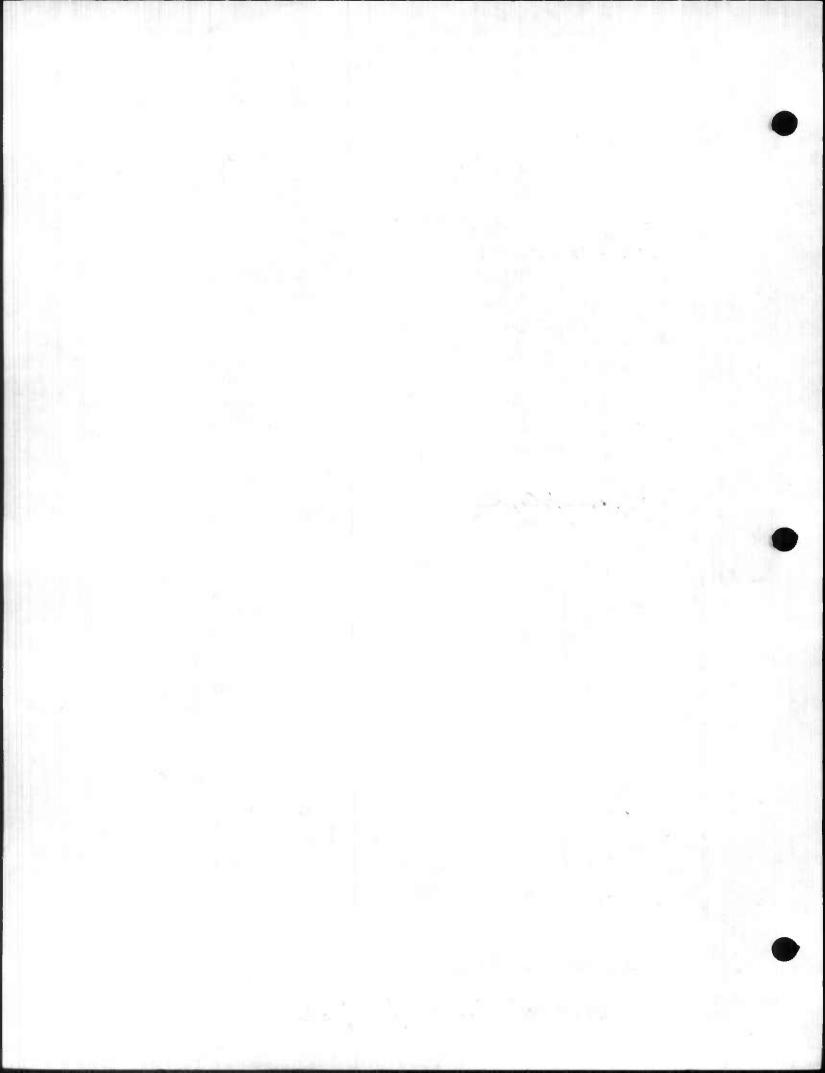
31. Date filed (Month, Day, Year)

FEB

10

DHMH 16 Rev 6/95

32. Registar's Signature



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Lanneau Davis February 8, 2000 4:45a.m. 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 8498 Greystone Lane 2A Adam Columbia Howard 7. Age (In yrs. last birthday) 55 vre If Under 24 Hrs 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Day, Year) May 12, 1944 Birthplaca (State or Foreign Country) Days Months Hours 220-42-7836 1 M 200 Yrs Pa. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits Md. Howard Columbia 1□Yes XX No 10f. Zio Code 10e. Street and Number 10g. Citizen of What Country? 8498 Greystone Lane 2A Adam 21045 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Bieck, White, etc. NOXYes 2 No If Yes, Give 1 Never Married 2 Narried Specify: Black 1 Yes 20No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Spring Grove 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Music Therapist 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Lanneau H. Davis, Sr. Marie L. Banks 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma A. Davis 8498 Greystone Lane 2A Adam Columbia, Md. 21045 wife 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 X Jurial 2 Cremation 3 Removal from State Crownsville Veterans Cem. Feb. 16 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LiceRtee 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting In death) Lest Due to (or es a consequence of) Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide | Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated. | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

The lew requires that the deeth certificate be axecuted P.O. Box 68760. Records, Division of Vital ial or Attending Physician: The safer death.

It Director: After this certificate ed in by the funeral director, pa To the Hospital within 24 hours a To the Funeral D completely filled

Physician

/Medical

Examiner

Funeral

Director

ahow

r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental thygiene. Important: If Item 27 is marked other than "natural", or the any Injury or other traumatic event, the Medical Exercise.

Physician /Medical

Examiner

use as the burial-transit pug

physician

s been signed by the should be detach

page 2 certificate

filled in by

Examiner

Physician/Medicai

Be Completed by

Medical Certification: To

Funeral Director

py

Completed

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with the Meryland

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aitimore. Maryland

State Registrar DHMH 16 Rev 6/95

FER 1 0 2000

29b. Signature and title of certified

OU 31. Date filed (Month, Day, Year)

30. Neme and add

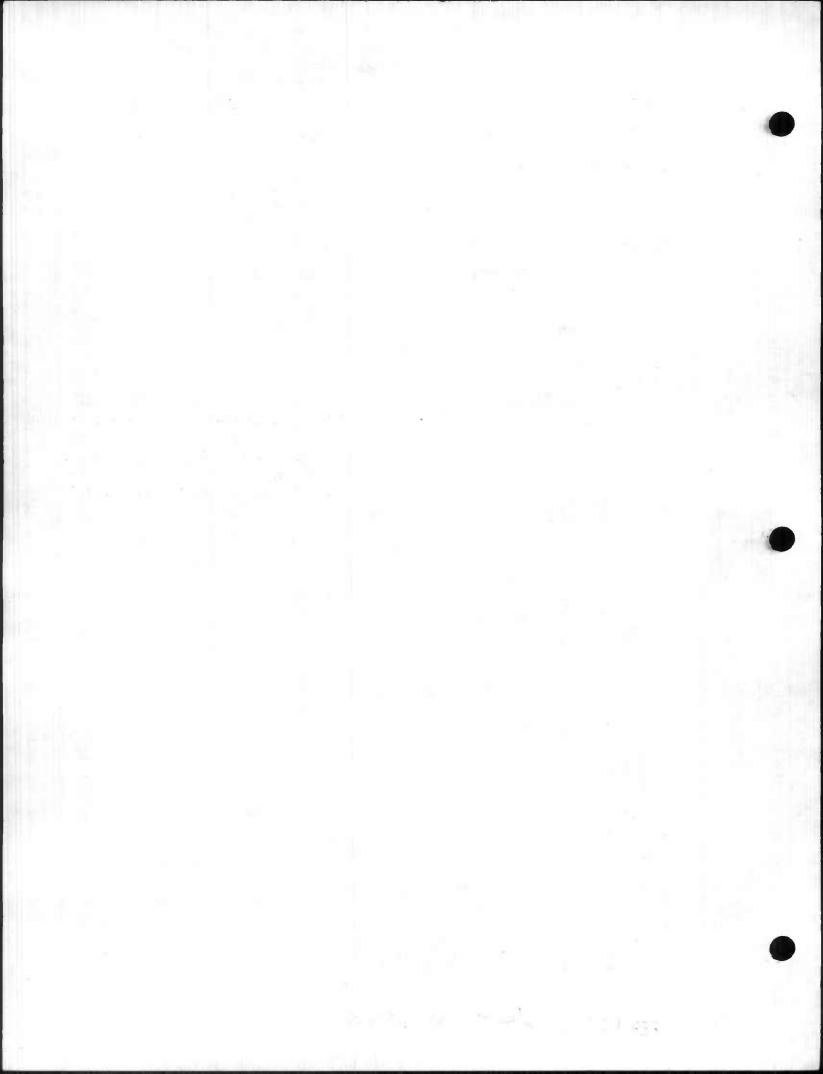
SLQUOT and TWOUND 32. Registrar's Signature

ress of person who completed cause of deeth (tem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

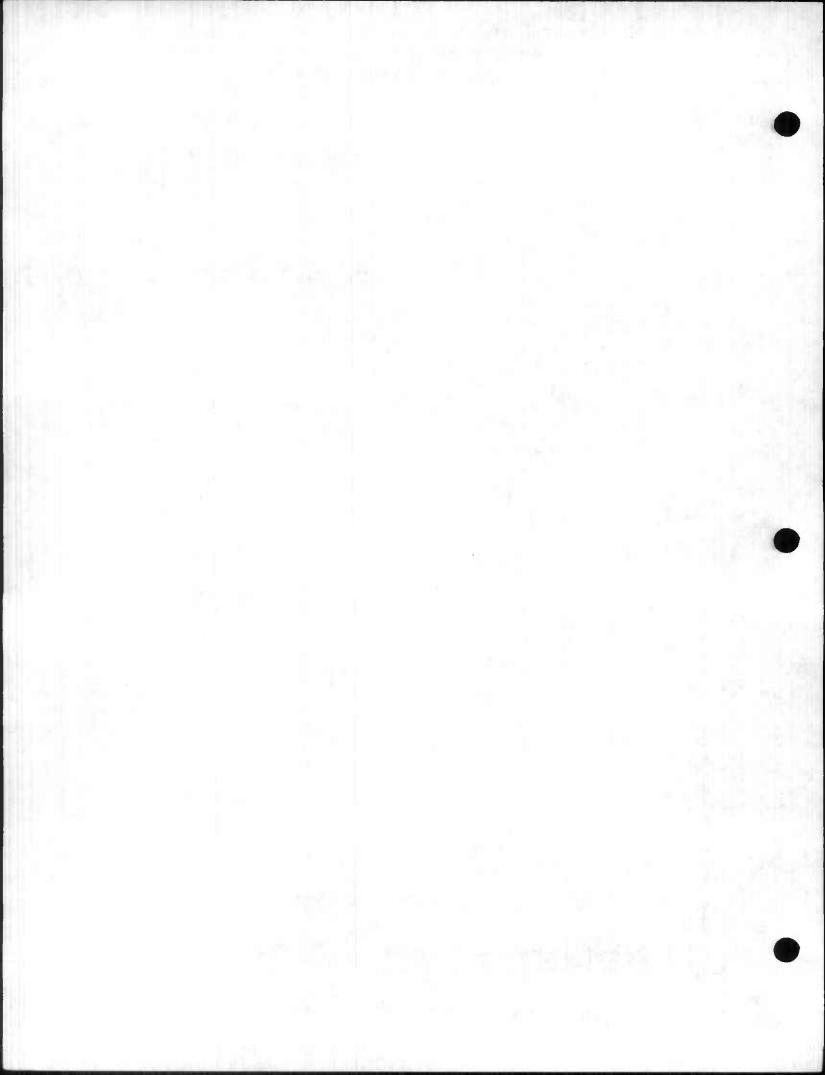
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 0 | 3

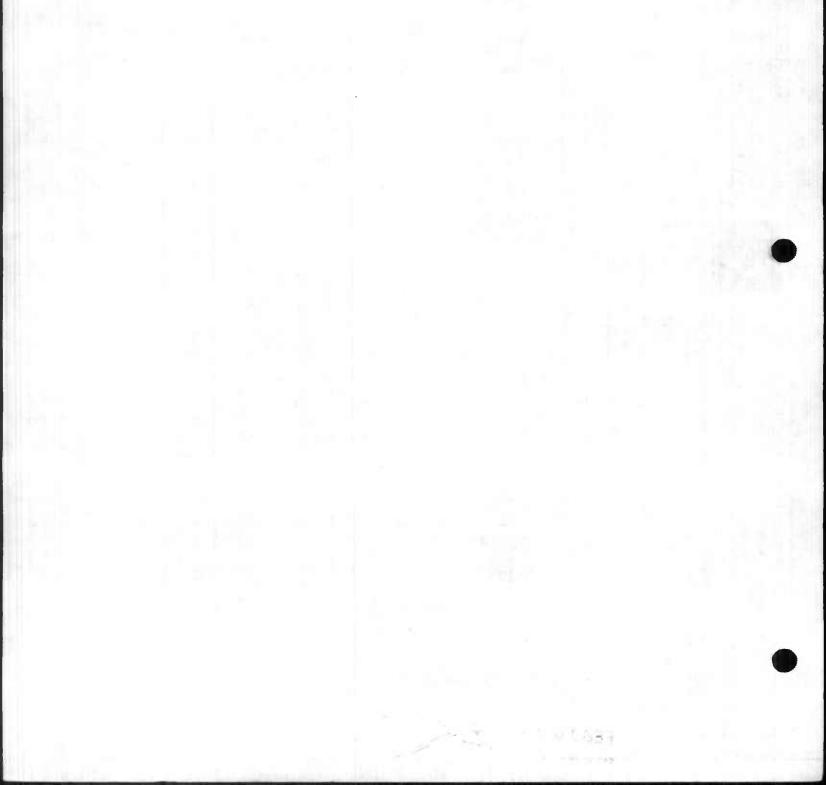
| | | | | | Ce | rtifica | te of | Death | | Re | g. No. | | 1010 |
|-------------------------|--|---|--|--|------------------------|--|------------------|-----------------------------|-----------------|--|--|---------------------|---|
| ioion | 1. Decedent's Na | ame (First, Middle, Li | nst) | | | | | | | 2. Date of Death Month | | (ear | 3. Time of Dea |
| ician dical | OHOMYSHIA FIACY FERRILARY O. 200 | | | | | | | | | 19:38 | | | |
| iner | Market Mark | (If not institution, gi | | | | | | | | cation of Death | 4c. County of | Death | |
| ш | | HNS HOPKII | | | | | | BALTI | | | N/A | | |
| | 5. Social Security N/A Usuel Residence | | Sex 7. | Age (In yrs. li | ast birthday) Yrs. | Months | Days 2 | If Under Hours | 24 Hrs. Min. | 8. Dete of Birth (Month, Day, FEB 2, | Year) 2000 | Mar Mar | place (State or For http) yland |
| | 10a. State | 10b. County | | 10c. City | , Town or Lo | ocation | | | | | | | 10d. Inside City Li |
| 28a-f ah coursed | | | | | | | | | 1.5 | | | 1 ☐ Yes 2 💢 | |
| Funeral Director | 911 F1 | ores Stre | et | | | 207 | | | | | g. Citizen of Wh USA | at Cou | ntry? |
| by by | | s arried 2 Married i 4 Divorced | 12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date | is? ZNo | | Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) I ☐ Yes 2 X No Specify: | | | | ecify Yes or No- Rican, etc.) | No- 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 191 | 15. Decedent's E | ducation | | 16a. Dece | dent's Us | Jal Occup | ation | t of worki | ing 1 | 6b. Kind of Busi | ness/In | dustry |
| Completed | Elementary/Se | condary (0-12) | College (1-4 | or 5+) | life. | | use retire | during mos d) | I OF WORK | ng . | | | |
| Co | N/A | | | | | N/A | | | | | N/A | | |
| Be | | e (First, Middle, Las | | | | | | 18. Mothe | | (First, Middle, M | | | |
| 2 | | Derrick F | lack | | | | | | Qu | onette C | lark | | |
| | | Name/Relationship | | | | - | | | | al Route Number, | | | |
| | Quonet | te Clarl | k/mother | | | | | | , Se | at Plea | asant, | MD | 20743 |
| | 20a. Method of D | | 78 | 20b. PI | ace of Dispo | osition (Nametory or | rme of other pla | ce) | | Date 2 | 0c. Location - Ci | ity or To | own, State |
| | 1 Bunial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2/10/00 Balti | | | | | | | | nor | e, MD | | | |
| | 21. Signature of | Funerel Service Lice | nsee | | 2 | 2. Name a | nd Addre | ess of Facili | tv | | | | |
| | Thomas Gregor Cremation Society of Marylan 299 Frederick Rd. Baltimore | | | | | | | | | | | | |
| sician | | or the disease, or con eart feilure. List only | | sed the death | | | | | | | | 1 | Approximate |
| | snock, or n | eart fellure. List only | one ceuse on eecl | n line. | | | | | | | | i | Onset and Dea |
| | Immediate Cause (Final disease or condition and BRAIN ANOMALY | | | | | | | | 03 747 | | | | |
| | disease or condi resulting in deeth | tion n) | a. BRAIN | | ALCOHOL: NO CONTRACTOR | | | | | | | - (| DAYS DAYS |
| er | | | MIII MTD | | as a conse | | | 770 | | | | i | |
| 듵 | | | b. MULTIPLE CONGENITAL ANOMALIES O2 D. Due to (or as a consequence of): | | | | | | | | D2 DAYS | | |
| Examiner | Sequentially list if any, leading to | conditions, immediate | | Due to (or | as a consec | quence of |): | | | | | - [| |
| | Cause (Disease or Injury | | | | | | | | | | | - 1 | |
| edical | resulting in deeth | | | Due to (or as a consequence of): | | | | | | | - 1 | | |
| 2 | | | d | | | | | | | | | | |
| lan | 1 | | | | | | | | | | | | |
| Physician/ | Part II. Other sign | nificant conditions | contributing to death | but not resu | lting In the u | inderlying | ceuse gi | ven in Pert | 1. | 23b. Did tot | sacco use contr | ribute t | o the cause of d |
| | | | | | | | | | | 1 □ Ye | N□ No 3 | Pro | bably 4 Uni |
| Completed by | | | | | | | | 13 | | 24a. Was an perform | | 81 | fere autopsy find vailable prior to empletion of caus |
| d E | | | | | | | | | | | | of | death? |
| ပ္ပ | | | | | | | | | | 1½ Ye | s 2 No | 1 | ☐ Yes 2√2 No |
| 8 | 25. Was cese ref exeminer? | erred to medice! | 14 - 24 / 4 | | | | | | e of Deeth | (Check only one |) | | |
| 2 | 1 Yes 2 | - | Hospital: | | ER/Outpatie | | UA | | | me 5 Reside | | | (y) |
| Certification: | 27. Manner of De 1 ☑ Natural | 5 Pending | | njury Day Year) | 28b. Time o Injury | f M | 28c. fnju Wo | ryaf rk? ∣Yes 2 🗆 | | 28d. Describe ho | w injury occurred | d | |
| Ca | 2 Accident 3 Sulcide | 6 Could not b | oe Diana d | Injune At ha | ma form -t- | | - | | | 28f. Location (Str | eet and Number | or Pi | al Boute Number |
| EL C | 4 Homicide | e determined | building, | 28e. Place of Injury - Af home, ferm, streef, fectory, offica building, etc. (Specify) | | | | | City or Town, | State) | JI FIUI | an i route (Yumipe) | |
| edical | 29e. Certifier (Check only | 1\(\tilde{\Delta}\) Certifying Pl 2 \(\tilde{\Delta}\) Medical Exa | hysician: To the be miner: On the basis | of examinati | vledge, deet | h occurre | d et the ti | me, dete en opinion, dea | nd plece, a | and due to the ce ed at the time, de | use(s) end mani te and place, an | ner as i | stated. o the cause(s) |
| Med | one) 29b. Signature ar | nd title of certifier | and manner | stated. | | 20 | ac Licen | se number | | 20 | d. Date signed (| Month | Day Yearl |
| | 290. Signature an | | | 01. | | | | | | 20 | d. Date signed (| MOHH, | Day, rear) |
| | OV | (KAK | enere | _th | YSICIO | 211 | RES- | 000 | | F | EBRUARY | 04 | 2000 |
| | 30. Name and ad | dress of person who | • | | | | | | | | = | | |
| - | SUSAN 1 | D SCHERER | MD 600 | NORTH | WOLFE | ST B | ALTI | MORE, | MD 2 | 1287 | | | |
| te | 31. Date filed (Mo | onth, Day, Year) | 32. Regi | strar's Signat | ure | 4 | do | acks | , | | | | |
| ar | | FFR 1 (| 2000 | Deper | | N | 190 | WAS ! | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death - Month 1,2000 **Physician** Frederick Februar Armatha 13:25 4c. County of Death /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Medical Maryland Baltimore Baltimore University If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Sta e or Foreign **Funeral** Sex 1□M 20F Months Hours Davs 243-24-8732 Usual Rasidance of Decedant Director 10a. Stata 10b. County 10c. City, Town or Location show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Instit if item 27 is marked other than "natural", or items 23a or 28a-1 show any or other traumatic event, the Medical Estation must be notified at any or other traumatic event, the Medical Estation must be notified as 1 Yes 2 No Maryland Director nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? arove Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yas, Giva Yaar or Datas: by 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 9 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 0 un 19a. Informant's Name/Ralationship (Type, Print) (Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Mrs. Mary 7/21 20a. Method of Disposition 20b. Place of Disposition (Nama of / Date 20c. Location - City or Town, Stata ry, cremator 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or once. 2000 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funeral Sarvige Licensas 22. Nama and Address of Facility a Balt North Ave 10. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final ROSEDS15 disaasa or condition resulting in daath) Examiner Dua to (of as a consequence of): Encephalopa MOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760 Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4X Unknown aigned to Records. à 24b. Were autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy performed? The law 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this 27. Mannar of Deat 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Ather Attending Natural 5 Pending Invastigation death. 1 ☐ Yes 2 ☐ No Hospital or Atlandi 24 hours after death Funeral Director: A 2 Accidant 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar (Check only one) 29b. Signature and titla of certifie 29c. License number 29d. Data signed (Month, Day, Year) February 4,2000 AU4176435B11581 MUS 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Kativa Byrd, MO South Green State Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 0 2000 **DHMH 16 Rev 6/95**

ORIGINAL



To the Hospital or Atlanding Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification: To

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Tyres 2 □ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurre SUBJECT FELL 28b. Time of Injury 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending investigation 1 DNatural 1 ☐ Yes 2 No UNKNOWN 6-5-99 2 X Accident DOWN STEPS 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Nymber or Flucal Route Number, AVE City or Town, Stete) 4/7 SHAMROCK AVE 4 Homicide HOME BALTIMORE, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier

31. Dete filed (Month, Pay, Year) State

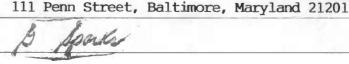
29b. Signeture and title of certifier

30. Neme and address of person

edical

temo 32. Registrer's Signature 2000

who completed cause of death (Item 23a) (Type, Print)



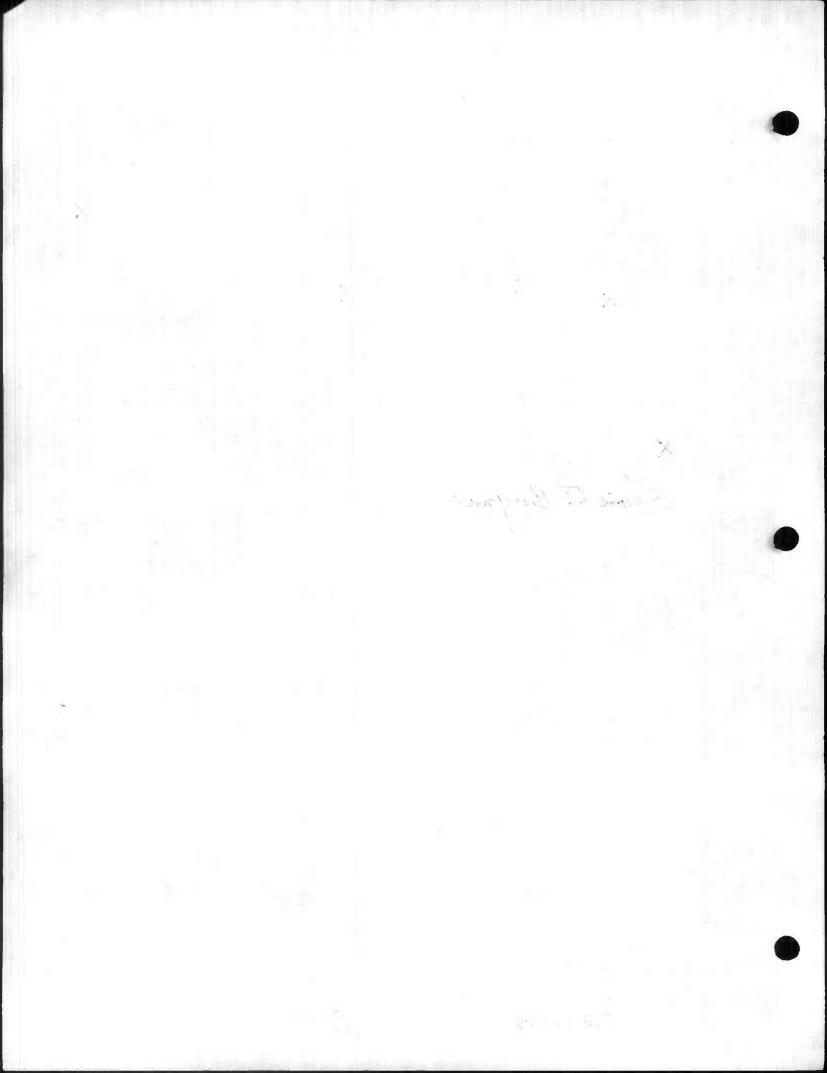
29c. License number

O.C.M.E.

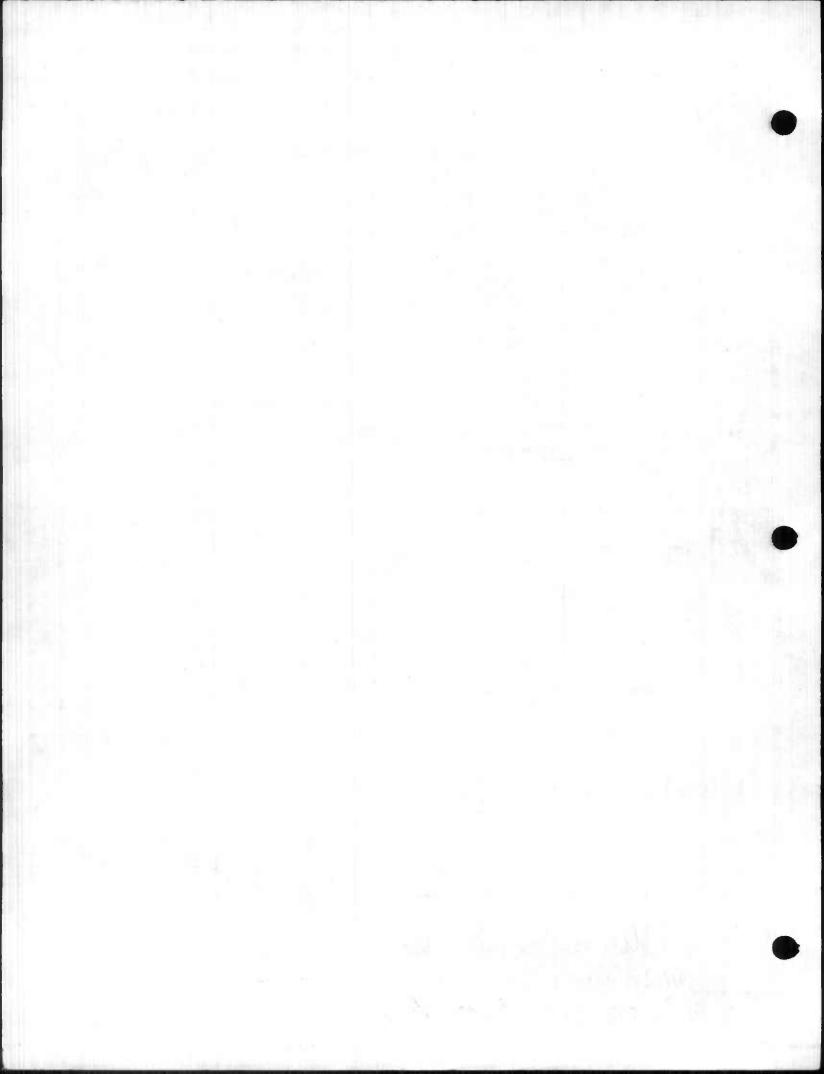
29d. Date signed (Month, Day, Year)

February 09, 2000

Registrar



| 00-0678-5 | 10 2/17/00 yg | | |
|--|---|--|---|
| B.K.S ame 27,28a,b,c,d,e UNKNOWN 0 | 2/17/00 yg nd item 23a ,f per me G780 Please Type or Print In Black Indelible Ink. Assure Al State of Maryland / Department of Health and M | Il Coples Are Legi | ble. |
| UNKNOWN 0 | 0-032 MARLENE ELIZABETH FOSTER Certificate of Death | Reg. No. | 00 04016 |
| Dhuniaian | 1. Decedeni's Nama (First, Middle, Last) | 2. Data of Death Month Day | 3. Tima of Death |
| Physician /Medical | Martene Fraben roster | FEB. 6, 200 | 0 0300 AM |
| Examiner | 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Lo 2020 DIVISION STREET BALTIMOR | , | N/A |
| Funeral | 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | B. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign |
| Director | Usual Residence of Decedant | Aug. 31,1957 | Maryland |
| anyland ehow | 10a. Stata 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| or 28a-f | 10e. Street and Number 10f. Zip Code | 10g. Citizen of V | 1 Vas 2 No |
| | | Tog. Citizen of V | ISA |
| | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yas, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, atc.) 14. Rac | e - American Indian, ck, Whita, etc. |
| D20 Jrs after Mr. or i | | Specify | Fran Amorican |
| | | ing 16b. Kind of Bi | usiness/Industry |
| 1 21215-0 ed within 72 ho ygiene. Per than "naturn. It, the Wedsell | Elamantary/Secondary (0-12) College (1-4or 5+) | ant Privato | Atorina Ca |
| and 2 be filed d other event, in | | a (First, Middle, Maiden Suman | 10) |
| Maryland 2 d 2 should be filed th and Mental Hygi 7 ie marked other treumatic event, | James Fenderson, Hatti | e Ihamp | SOh |
| Mar d 2 sh th and 7 le m treum | 19e. Informant's Name/Ralationship (Type, Print) (SISTET) 19b. Mailing Address (Street and Number or Run | al Route Number, City or Town, | State, Zip Code) |
| ore, N as 1 and 3 of Health item 27 | 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | Pata / 20c. Location - | City or Town, Stata |
| 0 2 2 | 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) | 1/17 para Duna | dalk, Md. |
| Baitim permit. Pag Depertment important: any Injury c | 21. Signatura of Funaral Sarvice Licensee 22, Nama and Addrass of Facility | Funeral Ho | me |
| | 23a. Parth. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. | Ave. Balto, or respiratory arrest, | Md. 2(2/6 |
| Physician | shock, or heart failure. List only one cause on each line. | | Intarval Between Onset and Death |
| /Medical Examiner | Immediata Causa (Final disaasa or condition rasulting in death) NARCOTIC AND COCAINE INTOXICATION | | |
| | Dua to (or as a consequence of): | | |
| acuted and -transit | | | |
| 68760, rificate be executed by the bunkling and the bunkling and the bunkling and the bunkling bunklin | if any, leading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated evants | | |
| 687 ng phy es the | rasulting In death) Last Dua to (or as a consequence of): | | |
| i Records, P.O. Box 68760, The law requires that the death certificate be see state has been signed by the attending physician a page 2 should be detached for use as the bunial-Completed by Physician/Medical Ex | d | | |
| P.O. thet the de by the detached | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | | ntribute to the cause of death? |
| S, P se thet se thet be delt by P P | | 1 Tos 2 I No | 3 Probably 4 Poniciown |
| Cords, P | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause |
| ai Record The law require cata has been si page 2 should d | | 1 | of death? |
| Division of Vital Records, for Attending Physicien: The law requires the after death. In the former this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by | 25. Was case rafarred to medical 26. Place of Death | 1 SYes 2 No | 1 Yes 2 No |
| of V hysici his cer il direc | examinar? 1) Yas 2 No Hospital: 1 Inpatiant 2 EP/Outpatient 3 DOA Other: 4 Nursing Ho | | er (Specify) AT SCENE |
| ding P Affect funers funers | 1 Natural 5 Pending (Month, Day Year) Injury A Work? | 28d. Describe how injury occur | red |
| Vision Attended to death | all suited and he 2/3/00 2. 43 | UNKNOWN 28f. Location (Street and Numb | per or Rural Route Number, |
| Dis affe or led in Cert | Unionicida Unionig, atc. (Specify) | City or Town, State) 2020 Baltimore, Md. | O Division st. |
| Division of Vita To the Hospital or Attending Physicien: With 24 hours after death. To the Funeral Directors After this certifical completely filled in by the funeral director, Medical Certification: To Be C | 29a. Certifier (Check only one) Cartifying Phyalcian: To tha best of my knowledge, death occurred at tha time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, 27 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and the control of the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and the control of | and due to the cause(s) and ma red at the time, data and place, | anner as stated. and due to the cause(s) |
| Within To the compile | 29b. Signal trained title of cartifier 29c. License number | 29d. Data signe | d (Month, Day, Year) |
| | > White me Yall or O.C.M.E | FEB. | 6, 2000 |
| | 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) HAYAYAYA DA LO GEW 111 Penn Street, Baltimore | no Marriand 1: | 1201 |
| State | 31. Date filed (Month, Day, Year) 32 Benistra's Signature | те, патулаки 2. | LZUI |
| Registrar | FEB 1 0 2000 Some B. Spacks | | |
| DHMH t6 Rev 6/95 | | | |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 5 50 pm WALTER FRAILEY GIES FEBRUARY 6,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1655 SEVERN CHAPEL RD. MILLERSVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 20 F Hours Days Months Yrs. 220.09.2001 DEC. 13, 1920 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1655 SEVERN CHAPEL RD 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE Y Yes 2 No If Yes, Giva 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE SERVICES SELF EMPLOYED 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) WALTER G. GIES REGINA M. FAIRLEY 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1655 SEVERN CHAPEL RD. MILLERSVILLE, MD. 21108 DORIS W. GIES WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY INC 2.10.00 BALTIMORE, MD Succession Service Ficens 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINK 426 CRAIN HWY. GLEN BURNIE, MD 21061 23a. Part. Enter the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) memia Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 NA 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury st Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

and attending physician Physician/Medical the th 8 bengis P Completed **D860** certificata To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 10 Certification:

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Be

Funeral

Director

show

å Ç

death

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other treumatic avant pance.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

than "natural", or hema 23a or 28a-f show the Medical Examiner must be notified as

Box 68760 Records, Division of Vital

State Registrar

Medical

3 Suicide

29a. Cartifier

4 Homicide

(Check only one)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

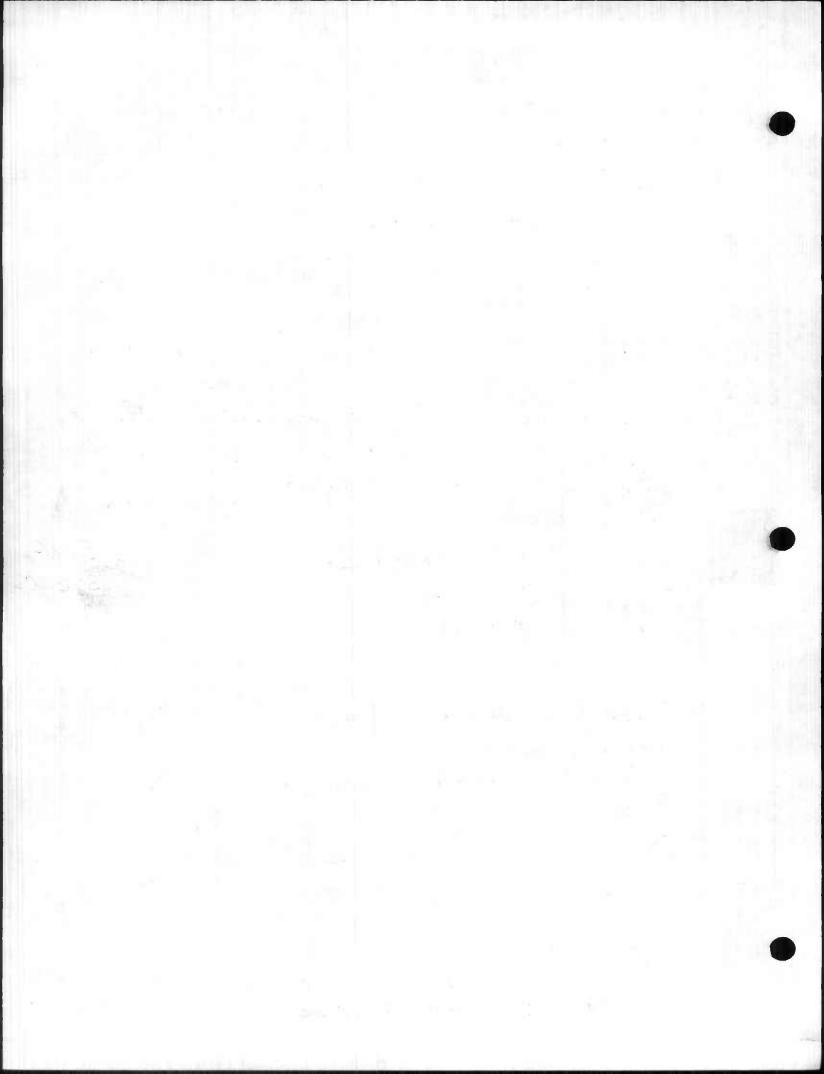
o completed cause of death (ttem 23a) (Type, Print) I.M 420

hellville Rd #102, Bowie, MD

TINOMan 31. Date filed (Month. 32. Registrar's Signature 2000

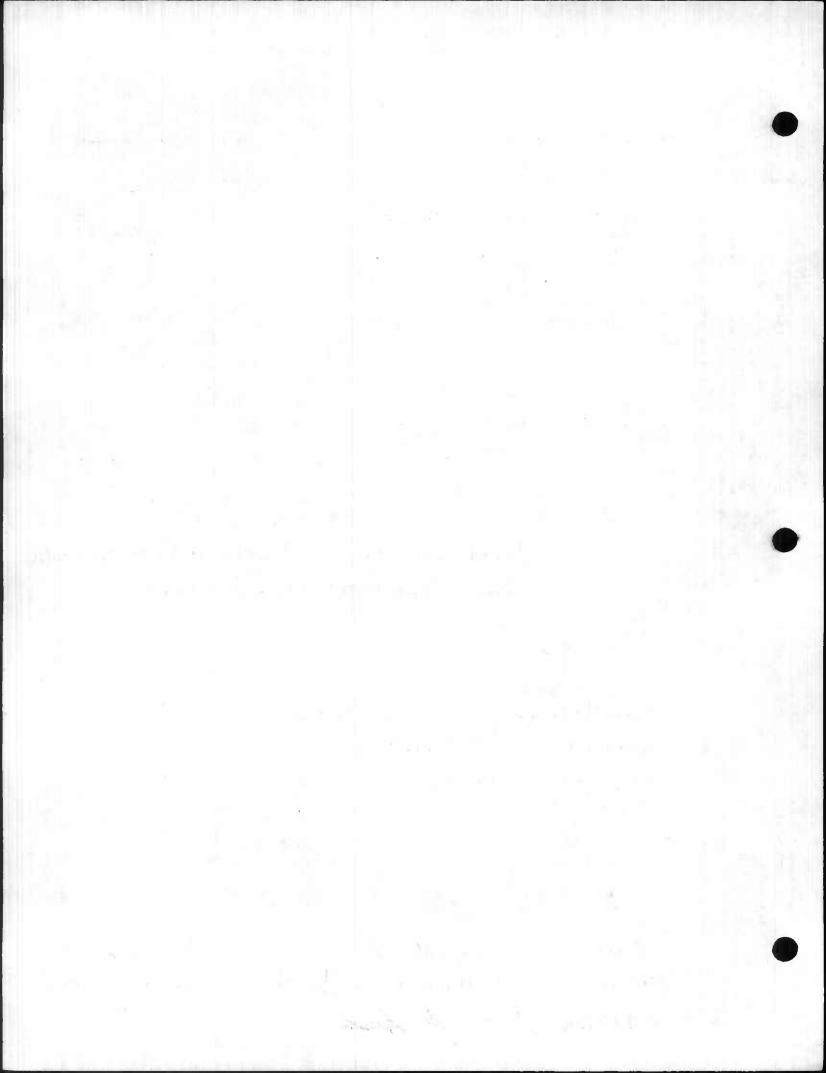
6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate of | Death | Reg. N | 00 1 | 14010 | | |
|--|--|---|--|---|--|---|--|--|--|
| Physicia | 1. Decedent's Name (First, Middle, Last) | | | 2. | Data of Death Month D | ay Year | 3. Time of Death | | |
| /Medica | Atili | | | | anuary 3 | | 11:00 P.M | | |
| Examine | 4a Facility Name (If not institution, give street and Genesis Eldercare Hai | | | 4b. City, Town, or Location of Death 4c. County of Death | | | | | |
| 120 | | | hday) If Under 1 Year | Baltimor | | Anne Arur | | | |
| Funeral Director | 5. Social Security Number 6. Sex 1 M 2 M | F 87 Y | rs. Months Days | Hours Min. | Date of Birth (Month, Day, Yea 11y 7, 19 | 340 | place (State or Foreign ntry) ryland | | |
| 2 1 | Usual Residence of Decedent 10a. Stata 10b. County | 10c. City, Town | or Location | | | | 10d. Inside City Limits | | |
| the Maryla 28s-f sho notified at | | | | | | | | | |
| The M | Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Court | | | | | | | | |
| | | | | | | | | | |
| 5-0020 72 hours after de naturel, or lterra | 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced | Decedent Ever in U,S. d Forces? es 2\lambda No , Give or Dates: | 13. Was Decedent of H If Yes, specify Cub 1 ☐ Yas 2 ☑ No | lispanic Origin? (Specify an, Mexican, Puerto Ric Specify: | y Yes or No- an, etc.) | 14. Race - Ameri Black, White, Specify: W | | | |
| Maryland 21215-0020 2 should be filed within 72 hours at the and Martal Hygiene. 7 is merited other than "naturel", or trearmetic event, the Medical Exam | 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg 12th 17. Father's Name (First, Middle, Last) | ge (1-4or 5+) | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | pation during most of working d) | 16b. | Kind of Business/In | | | |
| CA SECTION | 12th | | Homemaker | | | Own Home | | | |
| be the day of other swent, | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name (F | | | | | |
| arylar should be of Menta merked method | • | alinauskas | | | onica Jas | | | | |
| Age and a supplemental and a sup | 19e. Informant's Name/Relationship (Type, Print) | | Mailing Address (Street | | | | | | |
| | Joan D. Sullivan / Da | | 02 Moore St | | | Maryland | | | |
| Baitimore, semit. Pages t at begannent of Hea montant if Nem iny Injury or other bios. | 20a. Method of Disposition 1 | om State | Disposition (Name of r, crematory or other place COSS Cemete | 2/1 | | Location - City or To | own, State Maryland | | |
| Balt permit. Departmental any inje | 21. Signature of Funaral Service Licensee | | 22. Name and Addre | , GC | | eral Home | | | |
| | 23a. Part 1. Enter the disease, or complications the shock, or heart tailure. List only one cause | - oper | | | | ore, Md. | 21225 Approximate | | |
| oertificate be executed ding physician and se as the bunk-Iransit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a co | ched Atonsequence of): | herosc | | | ηγασαίμ | | |
| P.O. BOX | | | | | | | | | |
| P.O. that the de detached | Part It. Other significant conditions contributing t | o death but not resulting in | the underlying cause giv | ren in Part I. | | | to the cause of death? | | |
| | | g Dyst | unctio | س د | 1 🗆 Yaa | 2. PNo 3 Pro | obably 4 Unknown | | |
| 25 \$ 80 | Diabetes | , Mell | itus. | | 24a. Was an aut performed? | av cc | fere autopsy tindings vailable prior to empletion ot cause death? | | |
| The law ate has the page 2 s | H xmerten | Sinu | | | 1 🗆 Yes | 2 1 No 11 | □Yes 2□No | | |
| Vital Provident: The securificate director, pag | | -0.0.1 | | 26. Place of Death (C | heck only one) | | THE WAY TO | | |
| - S 00 L | 1 Yes 2 No Hospital: | ☐ Inpatient 2 ☐ ER/Out | patient 3 DOA Oth | er: 4 Nursing Home | 5 Residence | 6 □Other (Speci | (y) | | |
| Affe fune | 27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation | ate of Injury Month, Day Year) 28b. Ti | jury Wor | y at 28d k? Yes 2 □ No | l. Describe how in | jury occurred | | | |
| Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | 3 Suicide 6 Could not be determined 28e. P. b. | lace of Injury - At home, far uilding, etc. (Specify) | 281. | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| Hospit 124 hour Funera sletely fills | 29a. Certifier (Check only one) 15 Certifying Physician: To 2 Medical Examiner: On the and n | the best of my knowledge, e basis of examinetion and nanner stated. | death occurred at the tir for investigation, in my o | me, date and place, and pinion, death occurred a | due to the cause(at the time, date a | (s) and manner as a nd place, and due t | iteted. to the cause(s) | | |
| Within To th | | | 29c. Licens | e number | 29d. D | ata signed (Month, | Day, Year) | | |
| | 1 Caliera | a to MK | 7 | 01459 | F | 0 8- 17 | 000 | | |
| 0 | 30. Name and address of person who completed of | cause of death (Item 23a) (T | ,, - | 1. | 0 11 | ~ | laryland | | |
| State | 31. Date filed (Month, Day, Year) 3 | 2. Registrar's Signature | Penning | fon Aue - | balt | more, K | laryland | | |
| Registra | EED 10 2000 | Davis la | 1: | | 2 | 1224 | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Morzell Griswold rebruary 9 2000 tion of Death 4c. County of Death 2:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A aryland Genera 5. Social Security Number If Under 1 Year Age (In vrs Birthplace (State or Foreign Country) **Funeral** Days 15 M 2□ F Months 84 254-12-8195 Georgia Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. N/A Baltimore XXYes 2 No Director 258-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or flams 23s or 812 Regester Ave. 21239 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes XXNo 11. Meritel Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Black Specify: à 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hyga reportant: If Nem 27 is marked other 17 Father's Name /First Middle (ast) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Williams (Caregiver) 521 Willow Ave. Balto., Md. 21212 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Zion Cemetery 2/12/2000 Landsdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licensee 5502 Winner Ave. Balto., Md. 21215 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neumonia Unknown disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed physician and is the buriel-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 42 Unknown signed I by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun Investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

altimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vitai

5RASWOL

State Registrar

DHMH 16 Rsv 6/95

ORIGINAL

inpleted cause of death (Item 23a) (Type, Print)

10 32. Registrar's Signature

Chale

123a) (Type, Print)
Maryland General Hospital Batto, Md.

Ture

Land Corner Live For 202 1 home ? . All the second of the second o

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene 06020 MILLIAM GRIER #23 PART I, 27, 28A-F PER MEO Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 2000 **Physician** William Lloyd Grier 6, FEB. 0934 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL E.R. BALTIMORE N/A Jan 12, 1944 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F 219-38-7698 Maryland 56 Yrs. Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f ahow ofcal Examiner must be notified at MD. N/A 1 XYes 2 No **Baltimore** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4025 W. Coldspring Lane 21215 IISA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 █ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2X Married 8 altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yas 2 X No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 1 yr University Custodian 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic averal and all Be William H. Grier Lillian Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Sheila D. Grier (Wife) 4025 W. Coldspring Lane Baltimore, Maryland 21215 of Disposition (Name of Data 20c. Location - City or Town, State 20a Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Ramovai from Stata Arbutus Memorial Park 2/11/2000 Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice 22. Nama and Addrass of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 23a. Part. Entar the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** fmmediata Causa (Final disaasa or condition resulting in death) /Medical NARCOTIC INTOXICATION Examiner Due to (or as a consequence of): Examiner certificata be executed burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): physician s the buriel 68760 Physician/Medical Dua to (or as a consequence of) USB 88 for use as Box (P.O. F Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown á 1 ☐ Yes 2 ☐ No been signed to should be det Records, þ 24b. Ware autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion/of cause of death? paga P. 2 No 2□ No 1 Diffee Vital 8 25. Was casa refarred to medical 26. Place of Death (Check only one) axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) adical Certification: To Division of this 28a. Date of Injury — (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of FOUND: 2000 Attending 5 Pending Invastigation 1 Natural UNKNOWN 1 Yas 2 No UNKNOWN death. 2 Accident after death Director: / d in by the 6X Could not be 3 Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number City or Town, State)4025 W. COLDSPRING 4 ☐ Homicide To the Hoepital o within 24 hours at To the Funeral Di completaly filled in FOUND AT HOME BALTO, CITY, MD. 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signature and fille of certifiar 29c. License number 29d. Data signed (Month, Day, Year) ,2000 O.C.M.E FEB. causa of death (Item 23a) (Type, Print) of person who comple estane 111 Penn Street, Baltimore, Maryland 21201 ose

Registrar **DHMH 16 Bev 6/95**

State

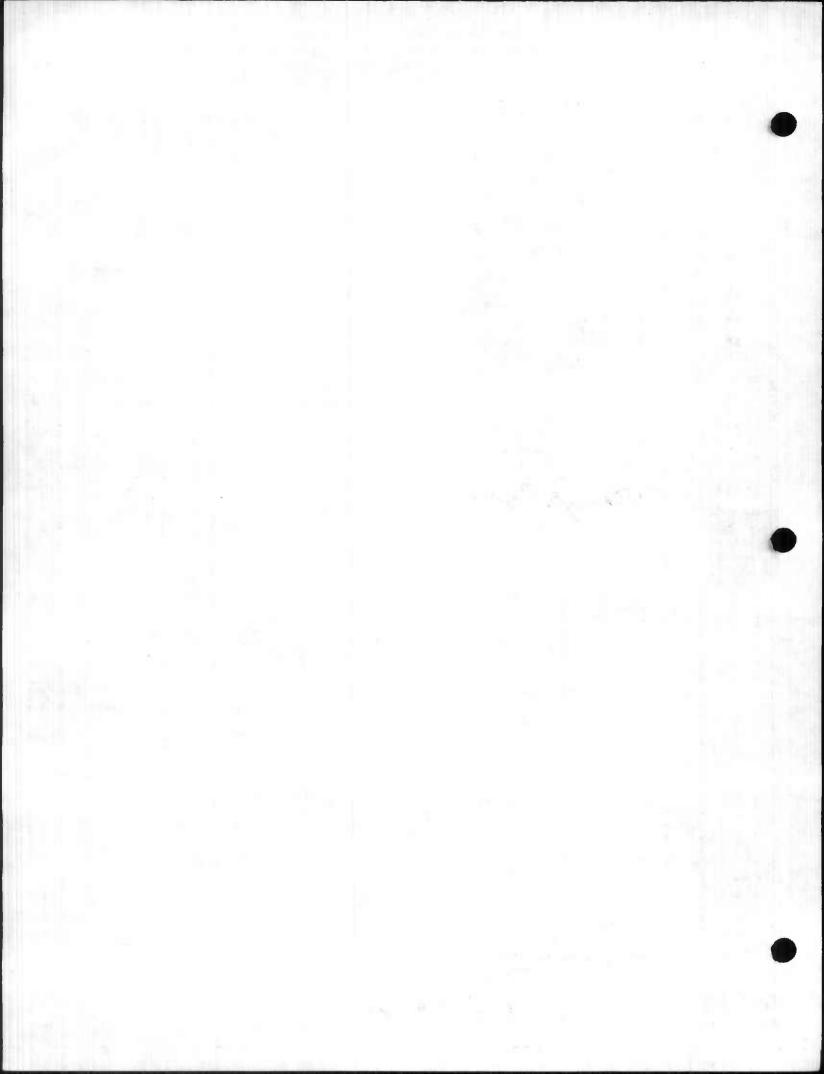
31. Date filed

Month, Day, Year)

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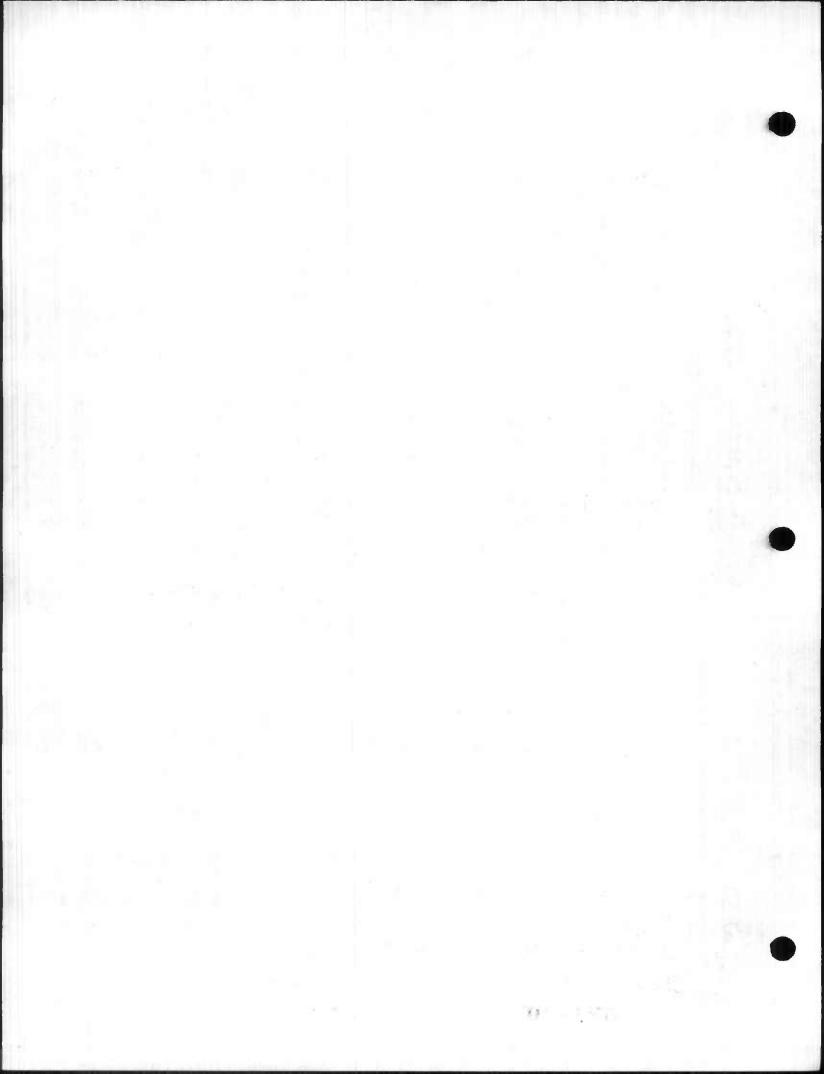
32. Registrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death February 8, 2000 Year **Physician** Alvin Huber 9:44PM Raymond /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Franklin Woods Nursing Center Rossville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Deys Months 10M 20F Hours 83 Dec. 1,1916 Director 217 07 9079 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or herns 23a or 28a-f ahow tre Magical Examiner raist be notified at 1 ☐ Yas 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 826 "A" Brunswick Road USA 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forces? 14. Raca - American Indien, 11. Meritel Stetus Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Giva
Yeer or Detes: Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☐XNo Specify: specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. ant: If Ifem 27 is marked other than ary or other traumatic awant, the Man Elementery/Secondery (0-12) College (1-4or 5+) Bricklayer Construction aitimore. Maryland 17. Fethar's Name (First Middle Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be Huber Hedwig A. Miller Otto 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11741 Hamilton Place White Marsh Maryland 21162 Alva G. Roop (sister) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or page. 8/9/2000 Greenmount Crematory Baltimore, Maryland 21. Signature of Funeral Straige Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex, Maryland 21221 23e. Pet 1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximata Intarvel Between Onset and Death **Physician** /Medical Immediate Cause (Final a. ACUTE MYDCARDIAL INFARCTION

Dua to (or es a consequence of): N 15 HOGE disease or condition resulting in deeth) Examiner Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or es a consequenca of): signed by the at the detached for P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 1 10 10a 2 No 3 Probably 4 Unknown HYPERTENSION, ESSENTIAL Division of Vitai Records. þ The law requires 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISONSE completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was casa raferred to medical exeminer? 26. Placa of Death (Check only ona) Hospitel: Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify) Medical Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1-Weturel 5 Pending 1 TYes 2 □ No 24 hours after death, Funeral Director: A investigetion 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29e. Certifier Ecritifying Phyafcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. tely (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, deeth occurred at tha tima, data and place, and dua to the cause(s) and manner stated. To the within 2 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, HILADELPHIA RD. MD 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State FEB 10 Denew Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Edward Holt January 31, 7:39 a.m. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7620 Maple Avenue Takoma Park Montgomery 8. Dete of Birth (Month, Pay, Year) Mar 17, 1932 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country), Georgia **Funeral** 10 M 20 F Days Months Hours 67 253-36-1555 Yrs Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Maple Avenue 20912 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married "natural", or Maryland 21215-0020 1 ☐ Yes 2 No Specify: specify: Black by 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiane. Important: if item 27 is marked other than "nah eny injury or other traumatic event, the Medical 2008. Elementary/Secondary (0-12) College (1-4or 5+) Operating Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Welbon Huff Minervia Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Elton Webb/Son 7443 Nye Drive, Highland, California 92346 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State Arlington National Cem. 2/8/00 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. Part Little List only one cause on each line.

7601 Sandy Spring Road, Laurel, Maryland 20707

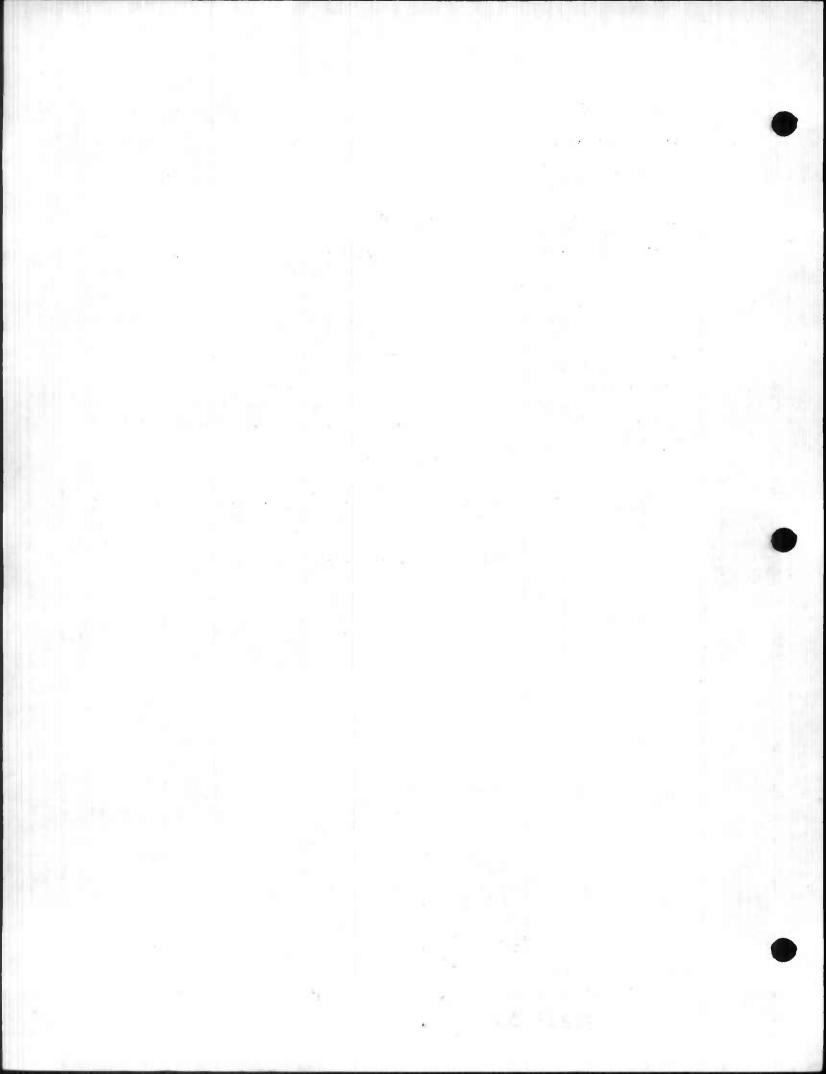
Approximate

Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ardiomyo disease or condition resulting in death) Examiner Due to (or as a consequence of): (Examiner Disease attending physicien and for use as the burlel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of) · Atherosc Box 68760, lerotic Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 Yes 2 M 25. Was case referred to medical examiner?

10 Yes 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? : After ! 5 Pending investigation To the Hospital or Attanding within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the funi or Attending 1 Natural 1 Yes 2 No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) SHOWber virsinia 0101058708 MID 30. Name and address of person who cor d cause of deatherform 23a) (Type, Print) WRAM C AUSC Washington MD Lance 31. Date filed (Month, Day

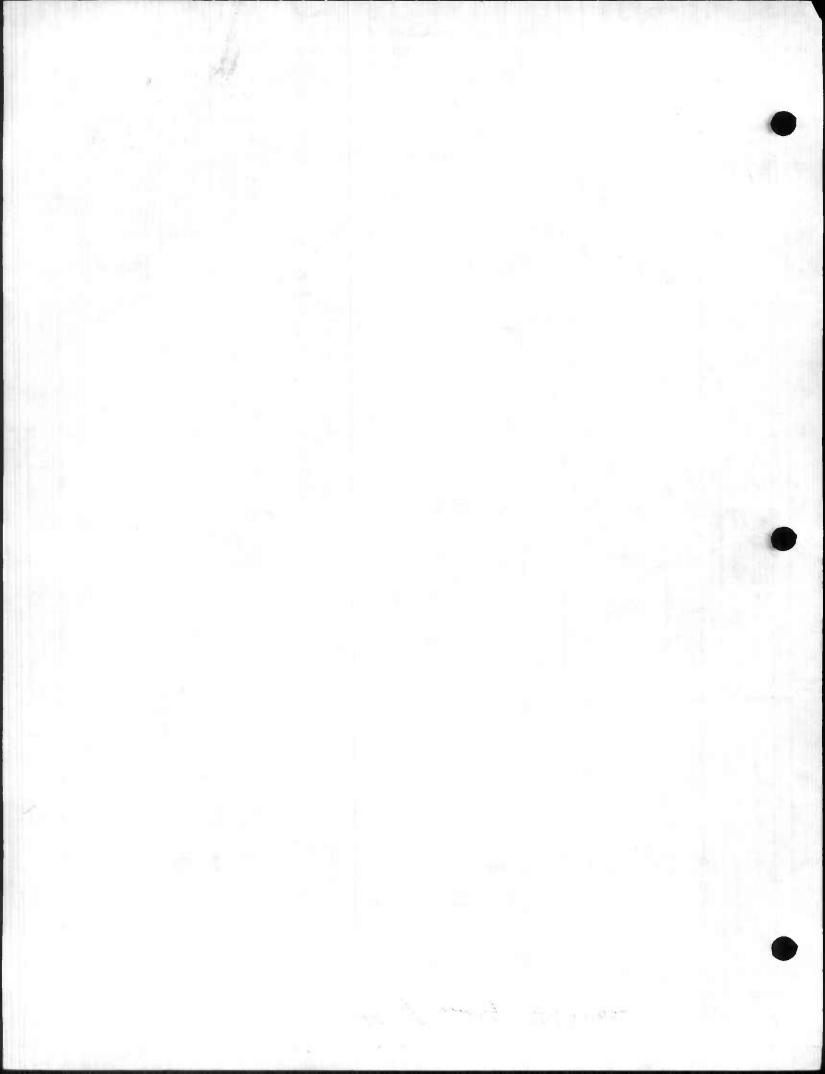
Registrar DHMH 16 Rev 6/95

State



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| WILBERT L. | LIZALA LANGALILA | | | | Il Copies Are Legi | ble. |
| ASP G780 2 | item 23a,27 per me S t /16/00 yg | tate of Maryland | Certifica | nt of Health and Nate of Death | Reg. No. | 04023 |
| Physician | 1. Decedent's Name (First, Middle, Last) | . 11. | + . 11 | | 2. Date of Death Month FEBRUARY 09 | 3. Time of Death |
| /Medical | 4a Facility Name (If not institution, give stree | 11S Har | IWell | 4b. City, Town, or L | | |
| Examiner | 633 N. AISQUITH ST | | | BALTIMORI | 000000000000000000000000000000000000000 | NA |
| Funeral Director | 5. Social Security Number 6. Sex 1 M M Usual Residence of Decedent | 2 F 7. Age (In yrs. last | Yrs. If Und Months | er 1 Year If Under 24 Hrs. Days Hours Min. | 8. Dute of Birth Month, Day, Year, P. D. 23, 1932 | 9. Birthplace (State or Foreign Clarify) |
| how the tal | 10a. Stete 10b. County | 10c. City, T | own or Location | | | 10d. Inside City Limits |
| th with the Manylar 23e or 28e-f show ast be notified at | Maryland V/A | | altim | ore in Code | 10g. Citizen of 1 | 1 Yes 2 No |
| # 5 M D | 633 N. Aisqu | ith St. A. | À | 2/202 | | LSA |
| De Las | A | Vas Decedent Ever in U.S. Armed Forces? | 13. Was Dec If Yes, sp | edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) 14. Rac | e - American Indian, ck, White, etc. |
| 020 020 by | | ☐ Yes 2 (X)No f Yes, Give fear or Dates: | 1□ Yes | 20 No Specify: | Specify | Black |
| 21215-0020 Within 72 hours at plans. I than "natural", or the Medical Exam | 15. Decedent's Education (Specify only highest grade con | | 6a. Decedent's Us (Give kind of w life. DO NOT | ork done during most of work | ing 16b. Kind of B | usiness/Industry |
| | Elementary/Secondary (0-12) | College (1-4or 5+) | Mainel | enance Wi | orker Hos | spital |
| D STEE S | 17. Father's Nama (First, Middle, Last) | tuall c | | 18. Mother's Nam | e (First, Middle, Maiden Suman | |
| larylan 2 should be and Mental se marked o sumatic ev | 19a. Informant's Name/Relationship (Type, F | Print) (SISTER) | 19b. Mailing Addre | ss (Street and Number or Run | al Route Number, City or Town. | State, Zip Code) |
| 2 5 N L | Mrs. Inez Alle | en la | 2801 5 | seamon A | ve. Balto. | Md. 21225 |
| More of H | 20a. Mathod of Disposition 1 Disposition 1 Disposition 3 Disposition | COM | e of Disposition (Natery, crematory or | other place) | Date 20c. Location - | City or Town, State |
| altimore, mit. Pages 1 as partment of Hea portent: If Item: y Injury or othe 28. | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | 2-0 | 22. Name : | and Address of Facility | Final II | Lowne, Ma. |
| m 88 5 8 | Delph L. | Kuss | 105ep | w. North | Ave. Balto | Md.2/2/6 |
| Physician | 23a. Part . Enter the disease, or complication shock or heart failure. List only one ca | ons that caused the death. I use on each line. | Do not enter the mo | ode of dying, such as cardiac | or respiratory arrest, | Approximata Interval Between Onset and Death |
| Physician / /Medical | Immediate Cause (Final disease or condition | SEIZURE DISO | RDER | | | |
| Examiner | resulting in death) a | - | a consequence of |): | | |
| cuted ansit | Sequentially list conditions, | Due to (or as | a consequence of |): | | 1 |
| | if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury | | | • | | |
| 68760, tificate be exerging physician at est the buriel-Aedical Ex | that initiated events resulting in death) Last | Due to (or as | a consequence of |): | | |
| P.O. Box 68760, nat the death certificate be asset by the attending physician at leteched for use as the burish. Physician/Medical Ex. | d | | | | | |
| cords, P.O. Box v requires that the death cert been signed by the attendin should be deteched for use letted by Physician/N | Part II. Other algnificant conditions contribute | ting to death but not resulting | g in the underlying | cause given in Part I. | The second state of the se | ntribute to the cause of death? |
| S, P es that igned by be dete | | | | | 1 Yes 2 No | 3 Probably 4R Unknown |
| Records, ne lew requires tr shas been signe tge 2 should be o | | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause |
| /ital Record | | | | | office of the | of death? |
| Vital sicien: The certificate irector, pa | 25. Was case referred to medical | | | 26. Place of Deat | 1)⊠-Yes 2 □ No | p⊈yes 2□ No |
| of V hysical this ce al direc | examiner? 1 □XYes 2 □ No Hospit | 1 Unpatient 2 UEH | | | me 5 ⊠ Residence 6 □Oth | |
| ding P. th. Atternation: | 27. Mannar of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accidant investigation | Ba. Data of Injury (Month, Day Year) | b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occur | Ted . |
| Division of or Attending Physiater death. Director: After this in by the funeral of ertification: To | 2 □ Suicide 6 □ Could not be | Be. Place of Injury - At home building, etc. (Specify) | , farm, street, facto | ry, office | 28f. Location (Street and Numb City or Town, State) | per or Rural Route Number, |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be sea within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be deteched for use as the burial-Medical Certification: To Be Completed by Physician/Medical Ex | 29a. Certifier 1□ Certifying Physician | | ing death conve | of at the time date and alone | and due to the cause(s) and ma | enner as stated |
| he Hoa in 24 h he Fun pletely | (Check only 2 Medical Examiner: (| | | | red at the time, date and place, | |
| To the comp | 29b. Signature and title of certifier | | 2 | 9c. License number | | d (Month, Day, Year) |
| | Denny Chi | spor | | O.C.M.E | FEBRUAR | RY 09,2000 |
| | 7 | red cause of death (Item 23 | | l Penn Street, | Baltimore, Ma | ryland 21201 |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | | | | - |
| Registrar | FEB 1 0 2000 | - Augustin | 1. Pf | TOURS! | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Yaar HARTILL MILDRED 22:10 EB 07 2000 4e. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MEDICAL CENTER BALTIMORE N/A ST. AGNES 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (Stata or Foreign Country) 1□M 2XF Days 101-09-2950 Yrs. OCT. 22, 1912 N.Y. Usuei Residanca of Decedent 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits HOWARD ELLICOTT CITY 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9522 LONGVIEW DRIVE 21042 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes, Z ☑ No If Yes, Give Yaar or Dates: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Reca - Amarican Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2X No Specify: WHITE Specify 3X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 4 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surname) SAMUEL WOLFERMAN RACHEL **ALEXANDER** 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA VANDERHEYDEN / DAUGHTER 9522 LONGVIEW DRIVE - ELLICOTT CITY, MD 21042 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremetion 3 N Removal Irom State 4 ☐ Donetion 5 ☐ Other (Specify) MT. HEBRON CEMETERY 2/10/00 FLUSHING, NEW YORK 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 21. Signetura of Funeral Servica License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory errast, and failure. List only one causa on each lina. 23a. Part1. Enta shock, or h Approximete Interval Between Onset and Death Immediete Ceuse (Final · CORONARY ARTERY DISEASE UNKNOWN disaasa or condition rasulting in death) 20 YEARS DIABETES Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Due to (or es e consequança ol): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yss 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of causa of deeth? 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2X No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturei 5 Pending investigation

Physician /Medicai **Examiner**

SUCE

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

MD

Funerai

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

with the Maryland

death

permit. Pages 1 and 2 should be filled within 72 hours effect. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or increase, any injury or other treuments.

altimore, Maryland 21215-0020

Examiner Physician/Medical p Completed

the burial-transit and been signed by the attending physiclan should be detached for use as the buria

this certificate hes After

Division of Vital Records, P.O. Box 68760, Be 2 Certification:

State Registrar

Hospital or At 24 hours after of

To the Hospital within 24 hours a To the Funerel C

Medical

MILDRED

3 Suicida 6 Could not be determined Pleca of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ HomicIde TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number

Masse Ar M.D. P12704

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NASSER NASSERI M.D. CATON 800

31. Dete liled (Month, Day, Year)

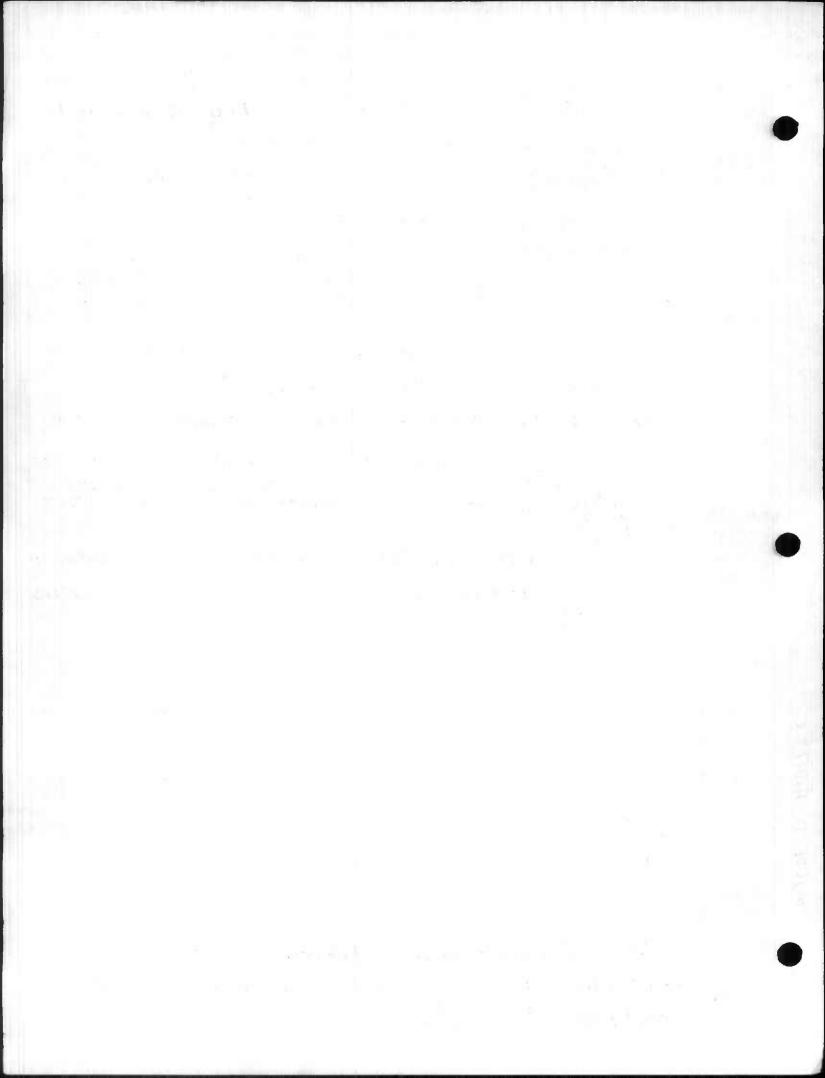
2 Accident

1 0 2000

32. Registrer's Signature

AVE BALTIMORE MARYLAND

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middia, Last) 2. Data of Death 3. Tima of Death Day 2 Month Year HENDERSON tion of Death | Otc. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death rospital BALTIMORE Hours Min. 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex . Age (In yrs. last birthday) Months Days 1□ M 2♥ F 213 20 0357 Yrs 88 May 21, 1911 Maryland Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 114 A Governors Court U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedant Evar in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 Yas 2 No Specify Specify: White 3 ₩ Widowed 4 Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 7th Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Ada Loveless Lawrence Haney 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 4102 - 8th Street Frances McLean / Daughter Baltimore, Maryland 21225 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑Buriel 2 ☐ Cramation 3 ☐ Removal from State Glen Haven Memorial Park 2/11/00 Glen Burnie, Maryland 4 ☐ Donalion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Gonce Funeral Home P.A. 23a. Part1. Enter Iha disaasa, di shock, or haart failure. List 4001 Ritchie Highway Baltimore, Md. 21225 plications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each lina. Approximate tntervat Between Onset and Death Immediate Ceuse (Finel diseese or condition rasulting in daeth) Sequantially list conditions, if any, laading to immadiala cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a 12000 paralos Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yas 2 No 1 Yas 25. Was casa refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 3No 150 Inpetiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Death 28a. Date of injury (Month, Dev Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Panding Investigation 1/2 Vaturel 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed the burial-tran P.O. Box 68760, signed by t d be detact Records. certificate Division of Vital this Affler

Physician/Medical Examiner þ Be Completed or Attending Physician: P edical Certification: death. filled in by the within 24 hours after deat To the Funeral Director: Hospital

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Medical Examiner must be notified at applica.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

with the Maryland

completely To the

DHMH 16 Rev 6/95

State Registrar

2 Accidant

3 Suicida

29a. Cartifier

4 I Homicida

FFB

29b. Signetura and titla of certifier wane Kem hu

28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

0

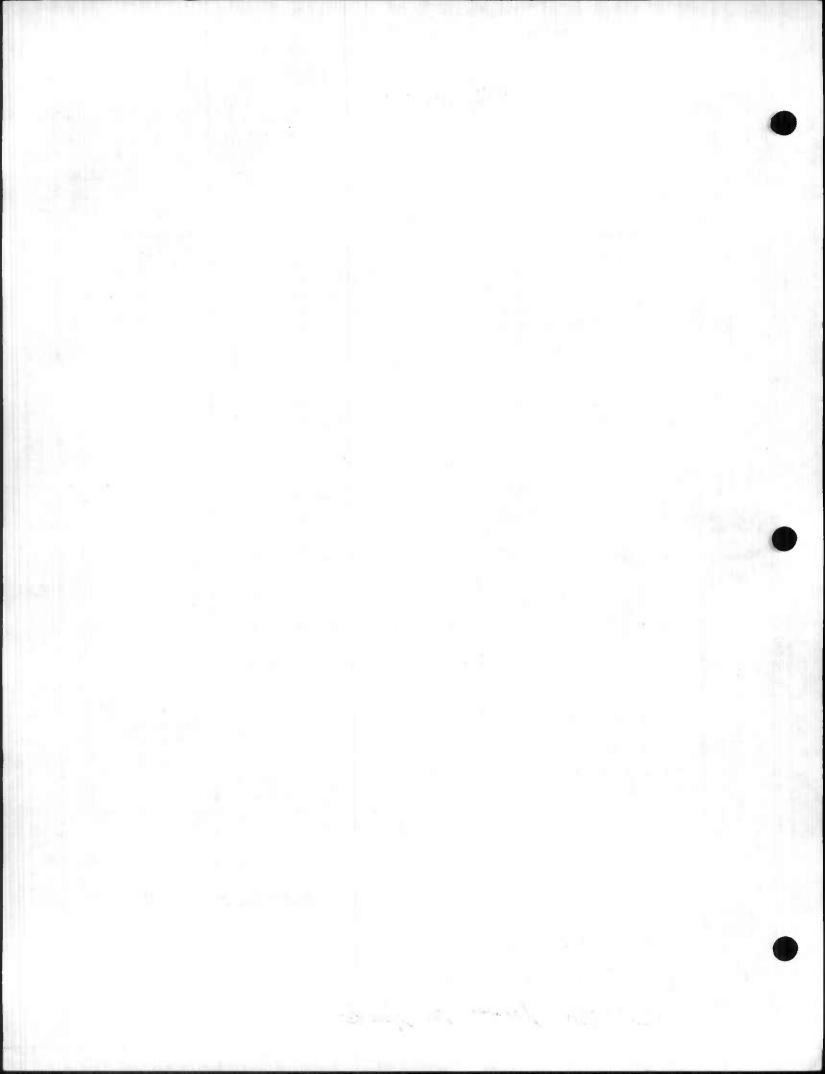
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed causa of death (Item 23a) (Type, Print)

NANGEN. KRYMD 3001.5. Hanver

31. Deta filed (Month, Day, Year) 32. Registrar's Signatura 10

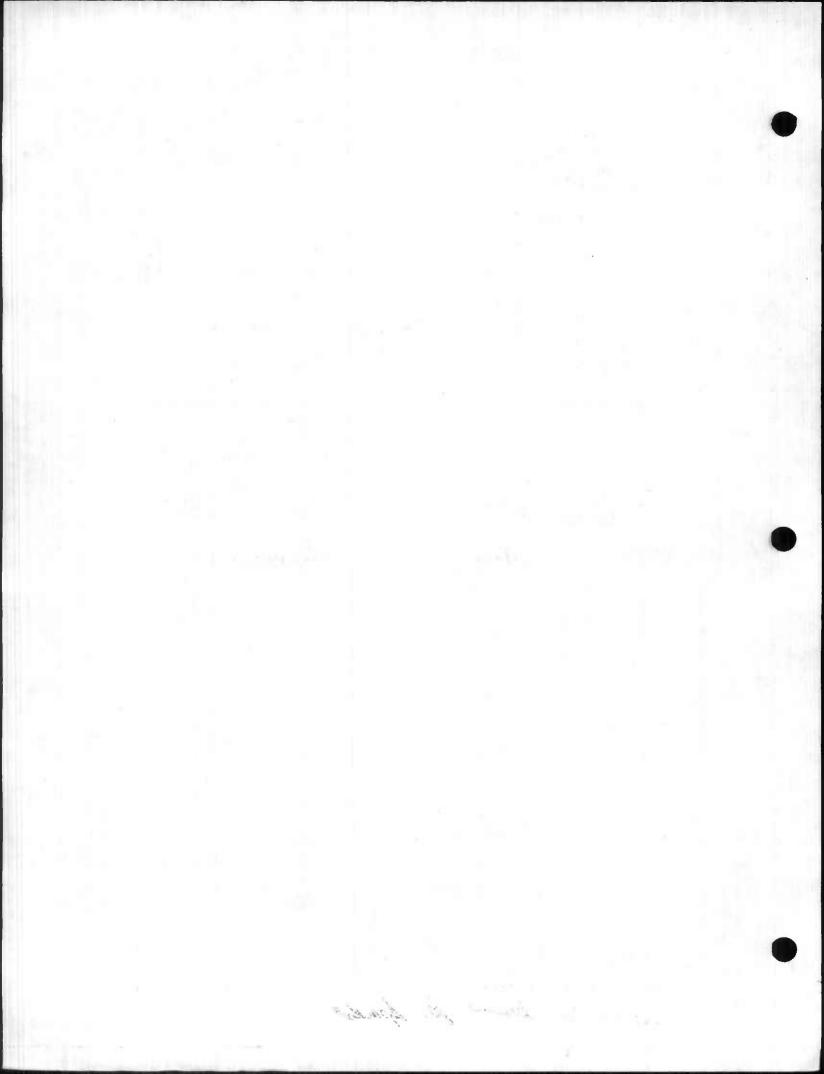
6 Could not be



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State of Maryland / Department of Health and Mental Hygiene 0.0 01.025

| | | | | Certificate of | | | eg. No. | 04050. | | |
|--|---|--|-------------------|--|--|--|--|---|--|--|
| Dhysisian | 1. Decedent's Neme (First, Middle, La | | | | 2. Date of Dea Month | th | 3. Time of Death | | | |
| Physician /Medical | | John C. | Henry | | FEBRUA | RY 7, 20 | 000 6:36 P.M. | | | |
| Examiner | 4e Facility Neme (If not institution, giv ATLANTIC GENERAL | | | | 4b. City, Town, or L | f Death | | | | |
| Funeral | 5. Social Security Number 6. S | | n yrs. last birth | day) If Under 1 Year | | 8. Date of Birth | WORCESTER 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) | | | |
| Director | 214 66 0423 | X M 2□ F | 45 Yr | s. Months Days | Hours Min. | July 13 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| P Bu | 10a. State 10b. County 10c. City, Town or Location | | | | | | | | | |
| a-f show diffed at otor | Maryland Anne Ar | | 1 Yes 20 No | | | | | | | |
| atter death with the Marylas or Nems 23s or 28s-1 show unines. must be notified at / Furneral Director | | | | | | | | | | |
| 0 5 1 0 | 11. Merital Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Wes Decedent o If Yes, specify C 1 ☐ Yes 2 ☒ N | | | | ecify Yes or No- Rican, etc.) | 14. Race Bleck Specify: | 14. Race - American Indien, Bleck, White, etc. Specify: White | | |
| 15-C | 15. Decedent's Ed (Specify only highest gre | | 16a. D | ecedent's Usual Occu Give kind of work done ife. DO NOT use retire | petion during most of work | ing | 16b. Kind of Bus | iness/Industry | | |
| 1 21215-0 ad within 72 ho syplene. wer than "neturn ft, the Medical.] | Elementery/Secondery (0-12) 12th | College (1-4or 5+) | | uto Mechan | | | Auto | Service | | |
| Ind 2 the filed d other event, I | 17. Father's Neme (First, Middle, Last, | THE TREET | | | 18. Mother's Nam | e (First, Middle, i | | | | |
| ylan ylan ylan ylan ylan ylan ylan ylan | F | Rollin D. He | Ge | raldine | A. Houg | htling | | | | |
| Maryland d 2 should be file file and Mental Hy 7 is marked othe traumalic event | 19a. Informent's Neme/Reletionship (| | | Mailing Address (Stree | | | | | | |
| CINE | Antoinette Henry 20a, Method of Disposition | | | 32 Woodland | | | | and 21122 City or Town, Stete | | |
| Baltimore, semit. Pages 1 a Separtment of Hea mportant: If Item my Injury or othe mos. | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory of other place) Glen Haven Memorial Park 2/11/00 Glen Burnie, Mary. | | | | | | | | | |
| Ball permit. Depart import any inj once. | Meny & | Lones | | 4001 Ritch | | | | ome P.A. d. 21225 | | |
| Physician /Medical Examiner | Immediate Ceuse (Final disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or es e consequence of): Due to (or es e consequence of): | | | | | | | | | |
| 68760, ifficate be executed g physician and as the bunist-transit | | | | | | | | | | |
| 5 0 6 | | | | | | | | | | |
| P.O. BOX hat the death cert of by the attending letached for use. Physician/M | Part II. Other algnificant conditions o | ontributing to death but n | ven in Part I. | 23b. Did tobecco use contribute to the cause of d | | | | | | |
| | | | 1 D Y | 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknow | | | | | | |
| Division of Vital Records, P.O. Box to attending Physician: The law requires that the death certain death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physician/A | | | | 24a. Wes e | on autopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? | | | | |
| The the Page | | | 12 Y | es 2 No | 12 Yes 2 No | | | | | |
| Vita cien: ector, Be | 25. Wes case referred to medical axaminer? | th (Check only or | ne) | | | | | | | |
| Physic physic rai direction of To | 1⊠ Yes 2□ No 27. Manner of Death | Hospitel: 1 Inpatient | 2 ER/Outp | atient 3LI DOA | | Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred | | | | |
| on stine stine stine stine | 1 Neturel 5 Panding 2 Accident investigation | 28a. Dete of Injury (Month, Day Ye | ear) Inju | iry Wo | rk?]Yes 2 □ No | EGG. DOSGROOT | a now injury occurred | | | |
| DIVISION C DIVISION C salor Attending P salor death. al Director: After t led in by the funera Certification: | 3 Suicide 6 Could not be determined | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | |
| ne Hospi in 24 hou he Funer pletely fill edical | 29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | yalcian: To the best of m niner: On the basis of ex end menner steted | amination and/o | leath occurred et the ti or investigation, in my | ime, date and place, opinion, death occur | end due to the c red at the time, d | ause(s) and man late and place, ar | oner as stated. nd due to the cause(s) | | |
| To within | | | | | | | | | | |
| | stypes | 1 Vla | dy | | OCME | | FEBRUAR | Y 8, 2000 | | |
| 10 | 30. Nema and address of person who stephen S. R. | | (Item 356) (T) | rpe, Print) 111 Penn S | street, Ba | ltimore | Marvla | nd 21201 | | |
| State Registrar | 31. Dete filed (Month, Dey, Year) FEB 1 0 2000 | 32. Registrar's | Signeture . | Sparker | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day February 8, Jeffrey Joan Inslev 2000 12:15 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 22 Buchanan Road Baltimore Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Days 10 M 20 F 69 280-32-7652 JUNE 9. Ohio Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Buchanan Road 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc 1 ☐ Yas � ☐ No 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Joseph A. Jeffrey Virginia Bonney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Buchanan Road Baltimore, MD 21212 Alan W. Insley/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 IXCremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Crematory, Inc. 2/9/00 Baltimore, MD Metro 21. Signature of Funaral Sarvige Live 22. Nama and Address of Facility Tregorchik Edward A. Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Road Balti
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilura. List only one cause on each line. 299 Frederick Road Baltimore, 21228 MD Approximate Intervel Between Onset and Death Immediate Cause (Final diseasa or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 26a. Data ol Injury (Month, Day Year) 27. Mannar of Death

1 A Netural

2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be asscuted pug Division of Vital Records, P.O. Box 68760, the USe as been signed by the a should be detached t page 2 certificate funeral director, this After 24 hours after death.

Furnish Director: After in by

Physician

/Medical

Examiner

Euperal

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Funeral Director

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Completed

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death with the Maryland

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than ' Irry or other traumatic event, the Mar

Department of Important: If any Injury or

Physician /Medical

Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

State

Registrar

Baltimore, Maryland 21215-0020

5 Pending invastigation

6 Could not be detarmined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

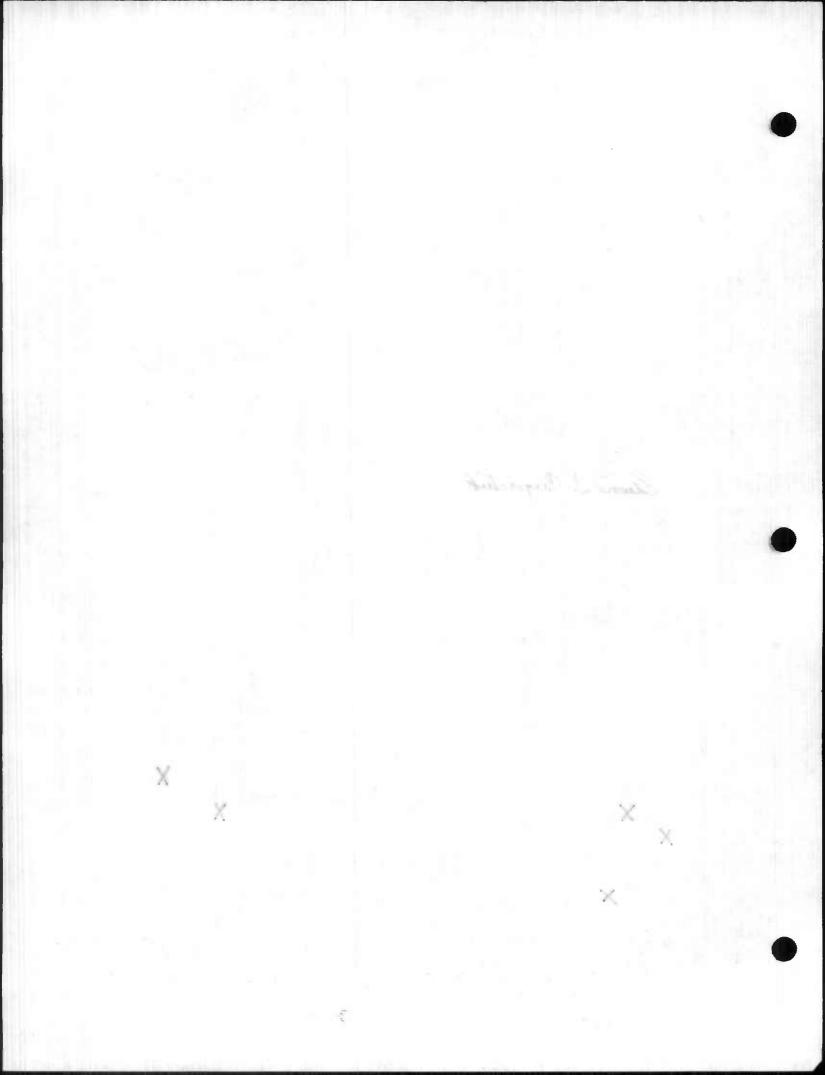
lated,causa of death (Item 23a) (Type, Print)

500 W Unwesty Pkuy Baltomore MD 21210

32. Registrar's Signatura Jane

Hospital

To the To the

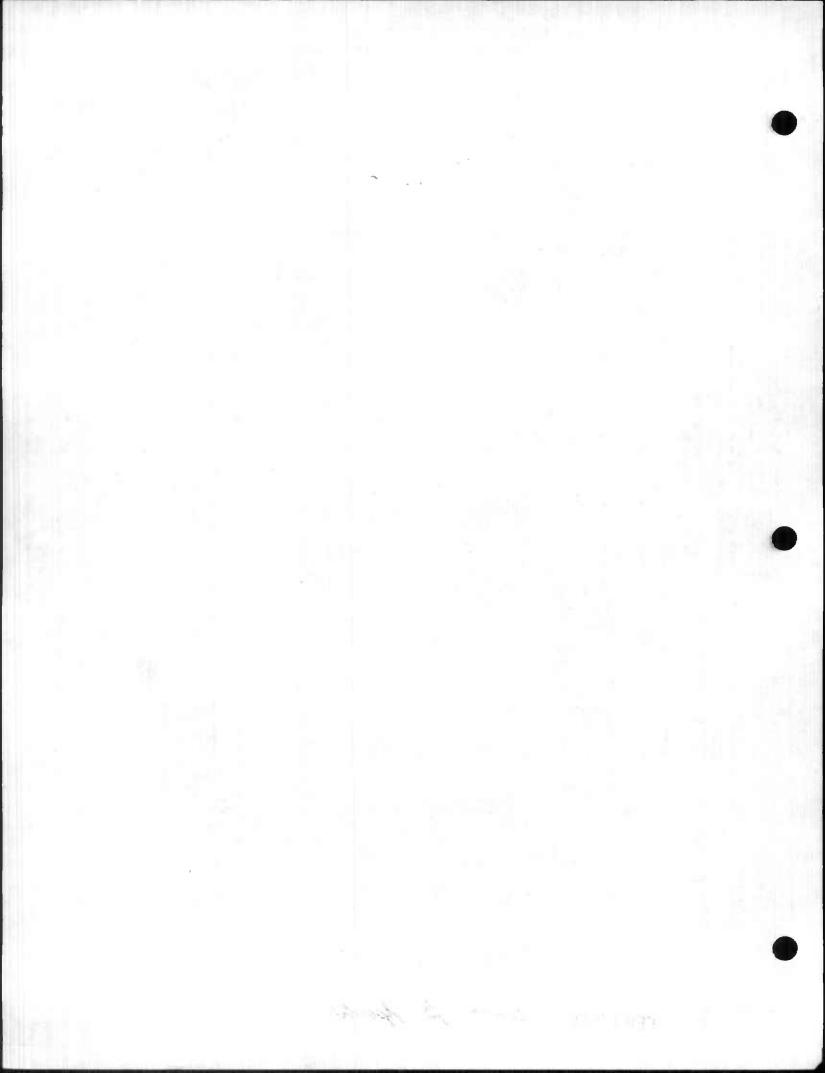


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 0 2 8

| Physician | 1. Decedent's Name (First, Middle, Las | 2. Dete of De Month | | 3. Time of Death | | | | | | |
|--|--|---|--|---------------------------------------|---|------------------------------------|---|--|--|--|
| /Medical | Edward | D. I | velan | 4 | | 2 | 3 00° | 12:30 pm | | |
| Examiner | 4a Facility Name (If not institution, give 2220 Popl | | Stree | + | 4b. City, Town, or Balt | Limbre | | eath | | |
| Funeral Director | 5. Social Security Number 6. S 213-09-1041 | ex 7. Age (In y RDAM 2□ F 86 | rs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Da | | Birthplece (Stele or Foreign Country) Pa • | | |
| 28s-1 show notified at | 10a. Stete 10b. County Md. n/a | 10c. | 10c. City, Town or Location Baltimore | | | | | 10d. Inside City Limits XXX Yes 2 □ No | | |
| firer deeth with the Mar r ferma 23a or 28a-f all the must be needing. Funeral Director | 10e. Street and Number 2220 Poplar Grove | | 0g. Citizen of What Country? USA | | | | | | | |
| | 11. Meritel Stetus 1 Never Merried | 12. Was Decedent Ever in Armed Forces? 11 ★ Yes 2 No If Yes, Give Yeer or Detes: | Yes 2 No s, Give 1 Yes | | lispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No o Rican, etc.) | | merican Indien, Inite, etc. Black | | |
| natural, adea E | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | 16a. Deced | ent's Usual Occup and of work done | pation during most of word) | rking | 16b. Kind of Busine | ss/Industry | | |
| led within 72 hours sygiene. The than "netural", of it, in Middle Every Completed by | Elementery/Secondery (0-12) 12th Grade | College (1-4or 5+) | Crain | ONOT use retire Director | d) - | | Sparrows | Point | | |
| be filed withintal Hygiene. d other than event, or M. | 17. Fether's Neme (First, Middle, Last) | | | | | | Maiden Sumame) | | | |
| | Thomas Ireland | | | | Rachel K | elly | | | | |
| and 2 should be filed within and 2 should be filed within 127 is marked other than or traumatic event, trail. | 19e. Informent's Neme/Relationship (1) Leona Ireland | wife | 2220 P | oplar (| | | or, City or Town, State | At the second se | | |
| Pages 1 nent of He mrt: If Nen ury or oth | 20e. Method of Disposition 1 | Removel from Stete | | etory or other pla Forrest | | | 20c. Location - City Owings M | Mills, Md. | | |
| permit. Departr Importr any Inf price. | 21. Signeture of Funerel Service Licen | terry le | 22. 25 | Name and Address O1 Gwynr | ess of Facility Nu IS Falls | tter Fur PKWY Bal | eral Home Ltimore, M | es, Inc. id. 21216 | | |
| Physician /Medical Examiner | 23a. Pert1. Enter the disease, or compands, or heart feilure. List only the feilure is the control of the contr | | rhy t | | | or respiretory a | rest, | Approximete Intervel Between Onset and Deeth | | |
| law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detected for use as the burtal-transit npleted by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last | b. Due to | o (or as a consequence of or a consequence of or a consequence of or a consequence of or as a consequence of or a consequence or a consequence of or a consequence of or a consequence or a c | lial Hence of): NO MIG | Infor | ction | | | | |
| attending attending for use as | David Other death | | | | | | | | | |
| that the death cert hed by the attending detached for use y Physician/M | Part II. Other aignificant conditions of Deme | | esulting in the un | derlying cause gi | ven in Pert I. | | | Probably 4 Unknown | | |
| A E E | | | | | | perfo | med? | b. Were autopsy tindings available prior to completion of cause of death? | | |
| ician: The la certificate ha rector, page | 25. Wes case referred to medical | | | | 00 Division (Div | 10' | | 1 Yes 2 No | | |
| hysician: his certific il director, To Be | examiner? | Hospitel: 1 ☐ Inpatient 2 | ☐ ER/Outpatient | 3□ DOA OH | 100 | oth (Check only o | dence 6 Other (5 | Specify) | | |
| | 27. Menner of Death 1 Netural 5 Pending 2 Accident investigation | 28e. Dete of Injury (Month, Day Year) | | 28c. Inju Wo | | | now injury occurred | pecity | | |
| 7 5 5 E | 3 Suicide 6 Could not be determined | be d 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. | | | | | | | | | |
| To the To the composite of the | 29b. Signature end title of certifier | ND WD | | 29c. Licens | | | 29d. Date signed (M | onth, Day, Year) | | |
| | C. Wilad | aeu | | | 0054 | 106 | ob 2/7/00 one St. Baltimore, | | | |
| 1 | 30. Name and address of person who o | ompleted cause of death (III | tem 23a) (Type, P | 10 | N. 60 | S 24 | 0 1 | | | |

DHMH 16 Rav 6/95



Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Edward Jones February 3:30 a.m. 7,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner University of Maryland Medical System Baltimore 5. Social Security Number 227-34-597 Usual Residence of Decedent If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (Steta or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 10 M 2□ F Yrs Director 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland 1 Yes 2 No Director 10a. Street and Number Apti 10f. Zio Code 10g. Citizen of What Country? Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Stetus r than "natural", or her the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Exemples 1 ☐ Never Merried 2 Merried 1 ☐ Yea 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa.; DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collecte (1-4or 5+) 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 8 Lo one ina 19e. Informant's Name/Ratationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Friend) 20b. Plece of Disposition (Nama of 20a. Method of Disposition Dete 20c. Location - City or Town, State emetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility u tue. Nor 23a. Partit. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear failure. List only one cause on sech line. Approximeta Intarval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Lung cancer 1 mouth Examiner Dua to (or as a consequance of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed physicien and s the burief-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): US0 88 signed by the et d be detached fo Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown acute renal failure Be Completed by 24b. Were autopsy findinga aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 PNo certificate funeral director, 25. Was case refarred to medical examiner? 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this 28a. Dete of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Natural 5 Pending investigation 24 hours after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier Medical

State Registrar

DHMH 16 Rev 6/95

To the Hosp within 24 ho To the Fund completely i

altimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) FEB 1 0 2000

(Check only one)

29b. Signature and title of certifier

22 South Greene 32. Registrer'a Signature

Street Baltimore, Maryland 21201 ooks

29c. License number

P11752

29d. Date signed (Month, Day, Year)

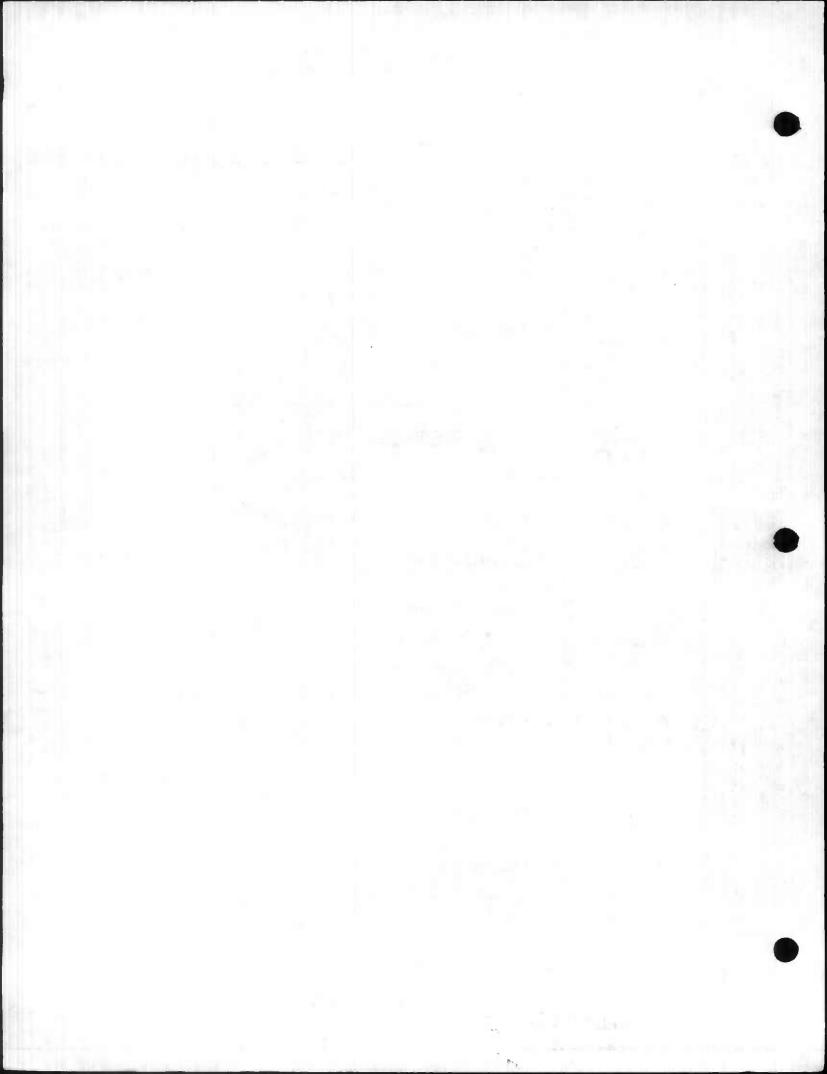
February 7, 2000

4132 2

Esterowitz

illeses

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Jackson Month Year **Physician** WILLIAM 11:30PM January 28, 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rehabilitation and EnTended Cave Baltimore N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □X X 2 □ F Hours 78 **Director** 219-10-9950 Dec. 26 1921 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND N/A CXYes 2 No Director BALTIMORE CITY 288-7 with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 25 21207 2803 SILVER HILL AVENUE U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herne 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hyglene.

Inter if flore 27 is marked other than "natural", or its ary or other traumatic event, the Medical Examics. NOTYPES 2 No If Yes, Give Year or Dates: 43/47 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION TRUCK DRIVER 12yrs altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) Be JOSEPH EVANS MINNIE BUTLER 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ethel Jett/Daughter 2803 Silver Hill Avenue, Baltimore, Maryland 21207 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete XXBurial 2 Cremation 3 Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 2-8-00 OWINGS MILLS, MARYLAND 2). Signatura of Foperal Service Licen 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 1206 W NORTH AVENUE.

Do not enter the mode of dying, such as cardiac or respiratory errest, 23 . Part 1. Enter the disease or compliant shock, or heert feilure. List only on Approximate Interval Between Onset and Death Physician Immediate Cause (Finel Stroke 3 years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 physicien Physician/Medical the Due to (or as a consequence of) 98 080 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? P.O. 2 1 Traa 2□ No 3 Probably 4 Unknown should be det Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? **page 2** 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural Hospital or Attendir n 24 hours after death. Ne Funeral Director: A pletely filled in by the fi death. 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M D0032548 re u February 1,2000 30. Nome and address of person who completed cause of death (Hern 23a) (Type, Print) 10 North Greene Street PERRY L COLVIN MD Baltimore, Maryland

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

Docks

32. Registrar'a Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year RANDOLPH JONES 12:10 FEBRUARY 2000 6 4a. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE BALTIMORE, MARYLAND GOOD JAMARITAN HOSPITAL 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Birthpleca (State or Foreign Country) 6. Sax 7. Age (In yrs. lest birthday) 1 M 2 F Months Days Hours 38 Yrs. 214-72-6378 7-16-6 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5615 HADDON AVENUE 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, atc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRACK FITTER RAILROAD 11 TH GRADE NIA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meldan Sumame) WALTER JONES SR YIOLA THOMAS 19e. Interment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) WINNIE GILLIAN SISTER 3308 HILTON ST. BALTO. MO. 20a. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or othar placa) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramovel trom State KING MEMORIAL PARK 102-10-00 RANDALLSTOWN. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Adgress of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23e. Part1. Enter the diagrams, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approx. Approximete Intervel Between Onset and Deeth Immediate Cause (Finel SEPSIS disease or condition resulting in deeth) week Due to (or es e consequence of): FAILURE HEPATIC Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence ot): Due to (or es e consequance of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings avellable prior to completion of causa of deeth? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 26. Piece of Deeth (Check only one) Hospital: 1 M Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 26d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not ba 3 Suicida 26e. Pleca of Injury - At homa, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner The law requires that the death certificete be axecuted Box 68760 P.O. Records. Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Physician

/Medical

Examiner

Funeral

Director

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Hems 2

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natural',

Hygiene.

permit. Peges 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 ie marked other tha any injury or other traumatic event, I'mal, Once.

Physician /Medical

physician and s the burial-transit

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signed t

page 2

certificate

the Medical Examiner must be notified

Director

Funeral

by

Completed

Be

Physician/Medical Examiner

þ

Completed

Be

Certification: To

Medicai

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

0

RONS. 31. Date tiled (Month, Dey, Year) State 10 Registrar

29a. Certifier

Kosen, MD ROSEN

29b. Signeture and title of certifier

5601 LOCH RAVEN BOULEVARD

RES- P13458

29c. Licansa numbar

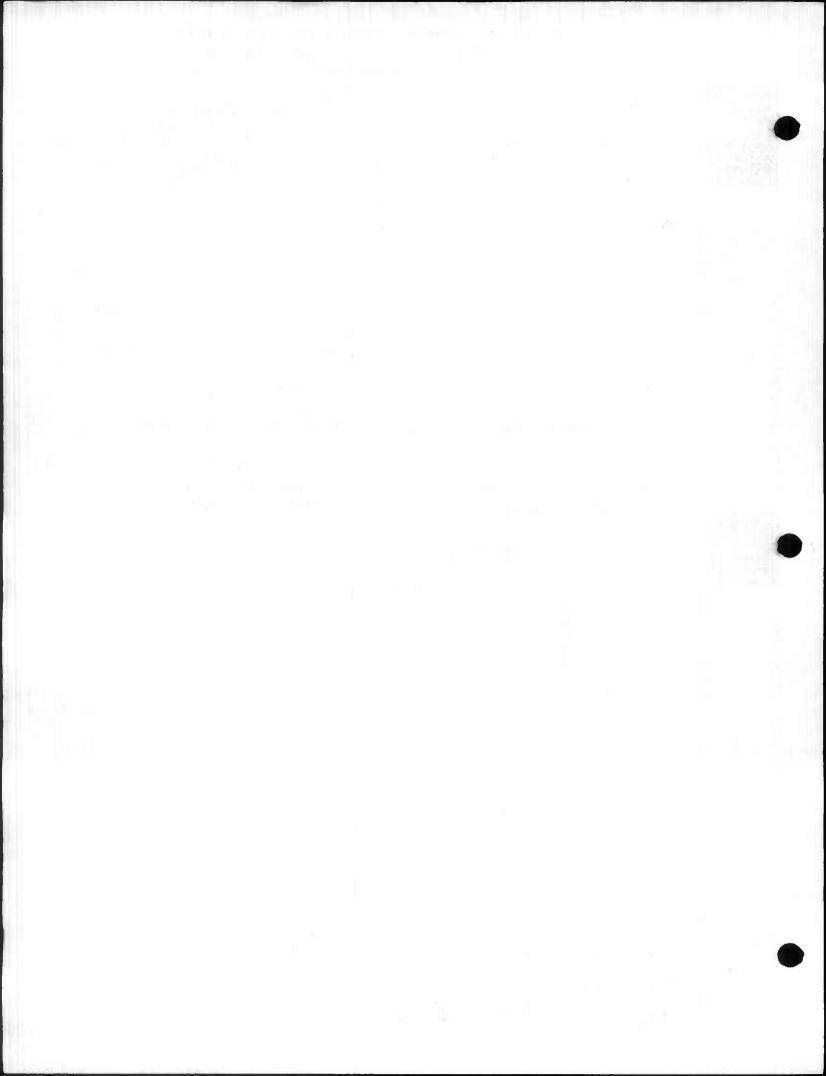
29d. Date signed (Month, Dey, Year) February 6, 2000

BALTIMORE, MARTLAND 21239-2995

30. Neme and eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

32. Registrar's Signature

DHMH 16 Bey 6/95



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01:032 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year Charles Earl Kirby, Jr. FEBRUARY 6, 2000 10:00 AM 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 13, 1916 6. Sex Birthplace (State or Foreign Country) Days Months MM 20F Hours MD. Yrs. 213-05-0954 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Baltimore Parkton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21120 17821 Foreston Rd. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Giva 1 ☐ Never Married 2 ☑ Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) BG&E Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Unknown Charles E. Kirby, Sr. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Kirby (son) 15456 Dover Rd. UpperCo MD. 21155 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 2/08/2000 Towson, MD. Carroll22. Neme end Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funerel Service Licensee Dennis C. 1050 York Rd. Towson, MD. 23a Parti Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, mock, or haert leiture. List only one cause on each line. Approximate Interval Betw Onset and Death CORONARY ARTERY DISEASE Immediate Ceuse (Finel disease or condition resulting in death) Dua to (or as a consequenca of): PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown END-STAGE RENAL DISEASE 24b. Wera autopsy lindings available prior to complation of cause of death? 24a. Was an autopsy performed? DIABETES MELLITUS 1 Yes 25 No 1 Yes 2 No 25. Was case rafarred to medical examiner? 26. Place of Death (Check only one) Hospitel: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2√ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

ahow

th and Mental Hygiene.
7 Is marked other than "naturel", or farm 23a or 28e-f ahov traumetic event, the Medical Examiner must be northed

. Pages 1 and 2 should be fittened of Health and Mental Hant: If Nem 27 le marked oth lury or other traumatic even

Department of Important: If any Injury or pace.

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

980 page 2

27. Magner of Deeth

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

29b. Signature and little of cartified

Examine physician and s the burial-transit Physician/Medical by 5 8 been si Completed Be Certification: To this funeral After

The law requires that the death certificate be executed Box 68760. 0 م Physician: Attending filled in by ò

of Vital Records. Division 24 hours after death.

Funeral Director: A Hospital within 2 \$

DHMH 16 Ray 6/95

State Registrar

Medical

31. Dete filed (Month, Dey, Year) FEB 1 0 2000

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

28b. Time of

28e. Pleca of fnjury - At home, lerm, street, lactory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

mullin m.o

30. Nema and addrass ol person who completed cause ol deeth (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND

28c. Injury et Work?

**Certifying Phyalcian: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated.

29c. License number

Doc 41410

1 ☐ Yes 2 ☐ No

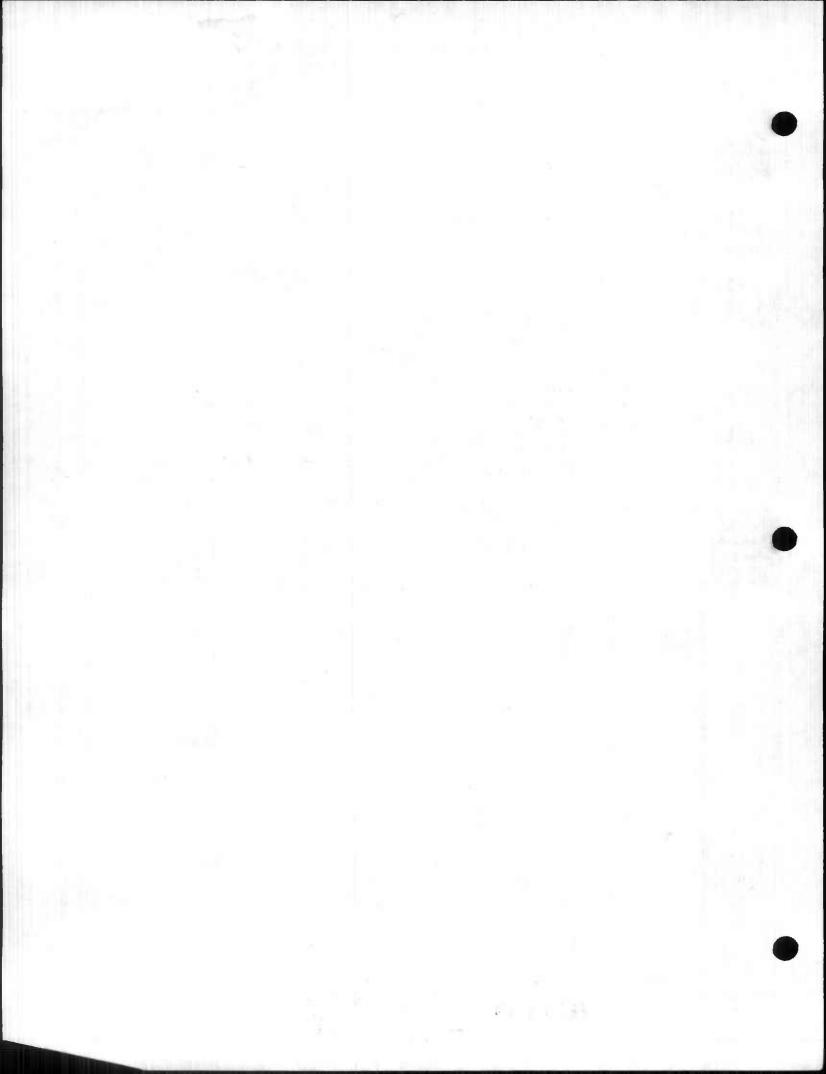
28d. Describe how injury occurred

February

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Deta signed (Month, Day, Year)

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year 9.00 Pm Lillian S. Krol tebruary 2000 J4c. County of Death 4a Facility Nema (II not institution, give street and number) 4b. City, Town, or Location of Death Roseda enter tim Square lone Social Security Number 8. Deta of Birth Month Day Year) 11-28-1916 If Under If Undar 24 Hrs. Birthplaca (State or Foreign Country) 7. Ana (In yrs. last birthday) 10M 20F Months Days Hours Min 83 218-01-0562 Usual Rasidance of Daceden 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Baltimore 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 21219 USA 7204 River Drive Rd. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Stetus Black, Whita, atc 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 No Specify: 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Assembler Independant Can 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fether's Nama (First, Middle, Last) Cecilia Salomea Fraczkowski John Szymanski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1828 Weyburn Rd., Baltimore, MD 21237 19e. Informent's Name/Ralationship (Type, Print) Mr. Walter Fraczkowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removel from Steta 2-11-00 Balto., MD St. Stanislaus 4 □Donation 5 □ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Fungal Service Licansas Kaczorowski Funeral Home Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately and cause on each line. Approximete Intarval Between Onset and Death Immediata Cause (Final diseasa or condition rasulting in death) eumonia Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Kena Stage Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 XNo 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 X No 1 Yas 1 Yas 2 No 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of tnjury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide †© Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifian (Check only one)

/Medical Examiner Physician/Medical Examine physician and the bunal-transit Box 68760 P.O. signed by a Division of Vital Records, by The law requires Completed page 2 s Be Certification: To this funeral Affer Attending depital c. depital dear. After dear. After dear. After de ferman d in 24 hour. the Funeral Direc-Hospital edicai within 2.

Physician

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Examiner

Funeral

Director

28a-f show

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Name 23a

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important: If Ihm 27 is marked of any injury or other Pages 1 and 2 should be

Physician

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MD

State Registrar

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30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

29b. Signatura and titla of cartifia

31. Dete filed (Month, Day,

Franklin 32. Registrar's Signetura renew

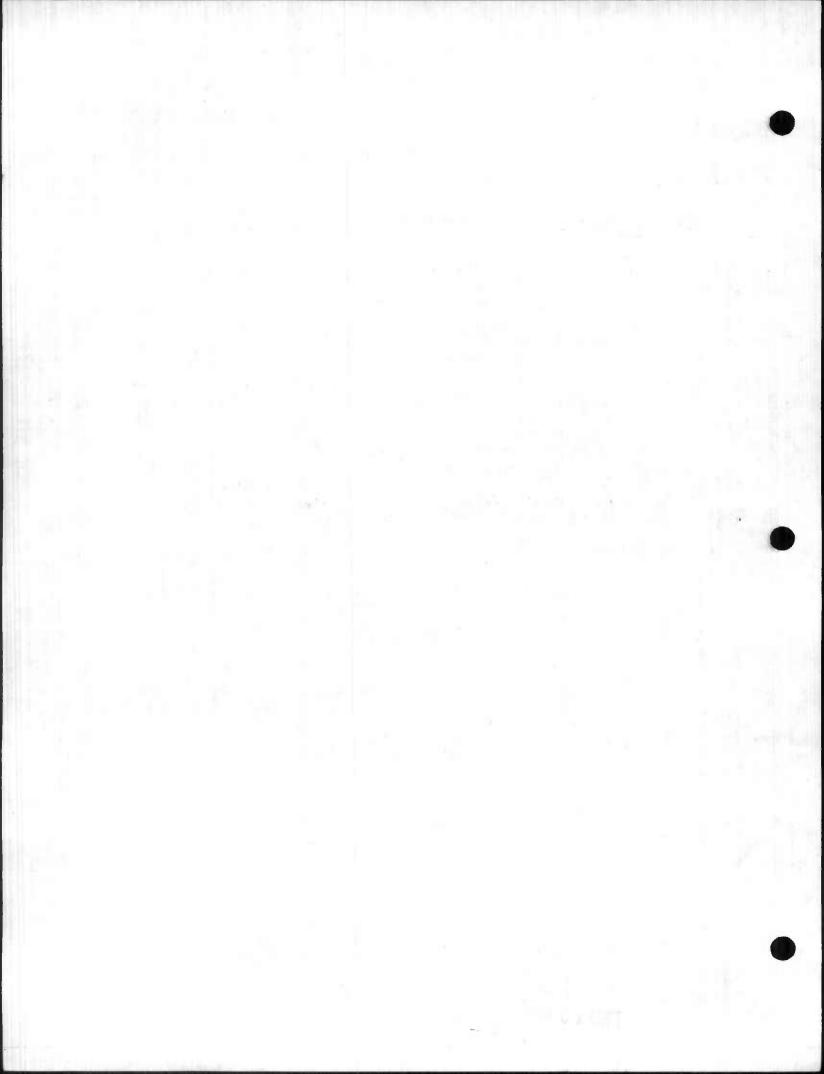
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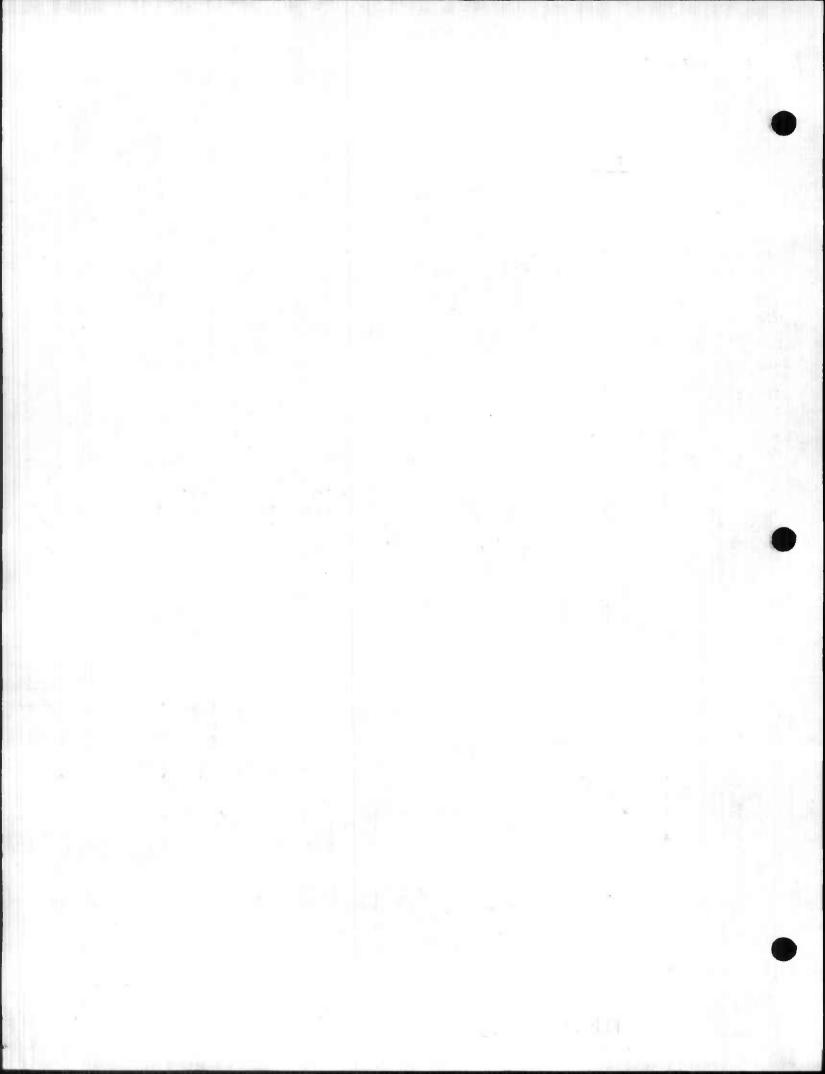


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04034 AMEND#5 PER F.H. G780 2-16-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Physician Robert Keller 02-07-2000 /Medical 10:00am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1209 Dundalk Avenue Baltimore 5. Social Security Number 2 1 2 - 4 4 - 2 7 5 6 If Under 1 Ye If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours ¥DM 2□F Davs Months 55 Director MD Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits -how r than "natural", or items 23a or 28a-f ahor the Madeal Exempler must be notified as 1 Ves 2 No Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours ettar deeth with ant of Health and Mental Hygiona. At I flem 27 is marked other than "natural; or thems 23e or any or other traumate event, the Medes Estation must be 1209 Dundalk Avenue 21222 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Armed Forces: 17 Yes 2 No If Yes, Give Year or Dates:Vietnam 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: à ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Crane Maintenance Betnler 18. Mother's Name (First, Middle, Maiden Surname) Bethlehem Steel Baitimore, Maryland 17. Father's Name (First, Middle, Last) Charles J. Keller 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Mrs. Peggy Lee Keller 1209 Dundalk Ave., Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or page. St. Stanislaus Baltimore, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Kaczorowski Funeral Home 23a. Perti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory emess, it in one, shock, or heart failure. List only one cause on each line. a AMP xim 21 222 Interval Between Onset and Death **Physician** veary /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be axecuted physician and the burlef-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 188 signed by the signed be deteched f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? paga 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificata funaral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death.
To the Funeral Director: Al
completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D005 who completed cause of death (Item 23a) (Type, Print) Hopkins Bayview MED. Center 4940 Eastern Ave-Baltimore MD 21224 EAlich-) chins 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2000 **DHMH 16 Rev 6/95**

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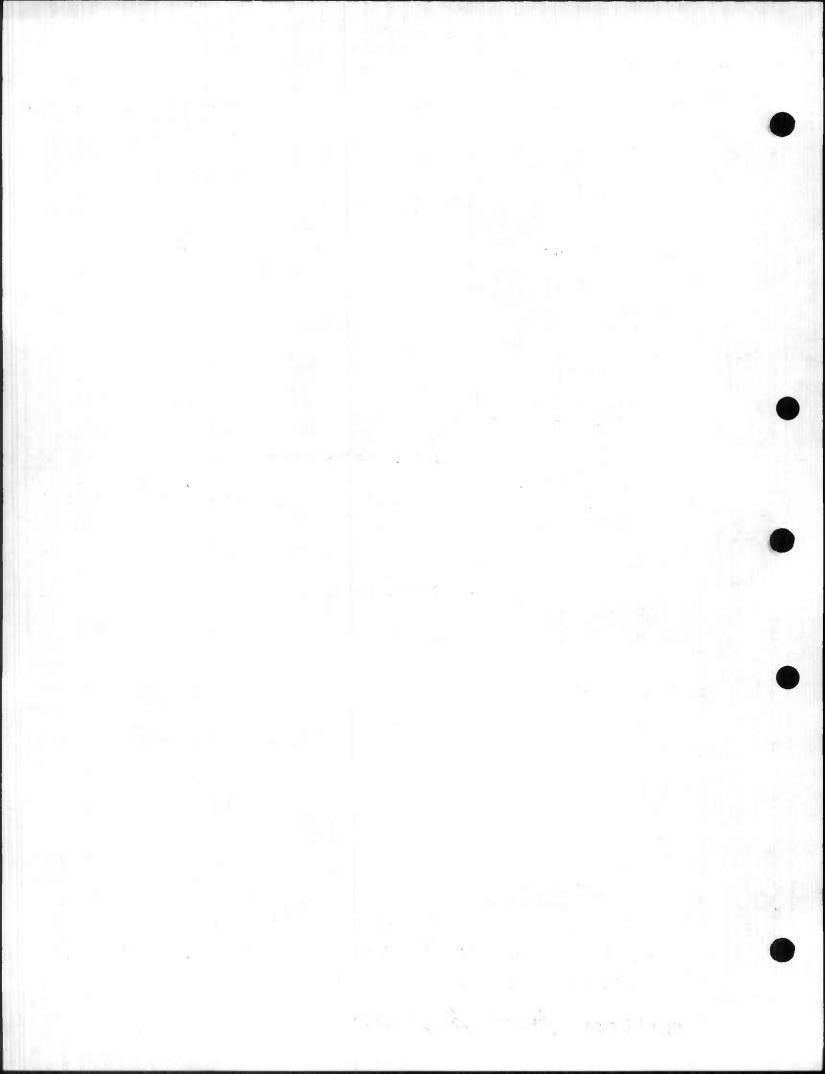


| State of Maryland / Department of Health and 5 per fh 6780 2/10/00 yg Certificate of Death | | | | | | | | Reg. No. 00 04035 | | | | |
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| Social Security N | umber 6. | | - | | | | | S. B. Date | of Birth | (ABI) | | ca (State or Foreign |
| | | THE PERSON SERVICE | 75 | Yrs. | Moditilo | Days | 110013 | | | | | PA |
| | 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | | | 10d | I. Inside City Limits |
| MD | BALTIM | ORE | BAI | LTIMORE | Ξ | | | | | | | 1 ☐ Yes 2 No |
| | | | | | 10f. Zip C | | | | 100 | . Citizen of \ | Whal Country | n |
| | AGTREE L | | | 10 100 | | | | 04 | | | - American | Indian |
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| (Page | | | | 16a. Dece | dent's Usual (| Occup | pation | nekina | 16 | b. Kind of B | usiness/Indus | stry |
| | | College (1- | 4or 5+) | life. | DO NOT use | retired | d) | anay. | | | 7017 | |
| Father's Name | (First. Middle, La: | | - | TEACH | SR | | 18. Mother's N | me (First. I | | | | |
| | | 7 | | SHERMA | AN | | ROSE | | | | | VAGMAN |
| a. Informant's No | ame/Relationship | (Type, Print) | | 19b. Maili | ng Address (S | Street | and Number or I | Rural Route | Number, (| City or Town, | State, Zip C | ode) |
| | | AMER / HI | | | | | LANE - | | 1 | | | |
| 1 X Burial 2 | ☐ Cremetion 3 | | tate | cemetery, crei | netory or other | er plac | | | | | G 10 | |
| | | | BA | | | | es of Facility | | | | | |
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| a. Part1. Enter th | ne disease, or co | mplications that ca | used the dee | 1 | | | | | | | i A | opproximete ntervel Between |
| anock, or near | nt railure. List on | y one cause on ea | CN IINB. | | | | | | | | Ö | Onset and Death |
| sease or condition | Final n | a. D | ulm | onar | 4 0 | m | bolus | | | | 4 | |
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| luse (Disease or at initiated events | injury | C | Due to (d | or as a consec | juence of): | | | | | | | |
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| t II. Other signifi | cant conditions | contributing to dea | ith but not res | sulting in the u | nderlying cau | ise giv | ven in Part I. | 23 | | | | he cause of death' |
| | | | | | | | | - | | | | |
| | | | | | | | -11 5 | 24a | | | availa | e autopsy findings lable prior to pletion of cause eath? |
| | | | | | | | | | 1 DV6s | 2□No | 104 | ves 2□ No |
| examiner? Hospital: Other- | | | | | | | eath (Check only one) | | | | | |
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| 1 Natural 2 Accident | 5 Pending | | , Day Year) | Injury | м | | | | | | | |
| 3 Suicide 4 Homicide 6 Could not be detarmined 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) | | | | Route Number, | |
| (Check only | 1 Certifying F | miner: On the bas | sis of examina | owledge, deat ation end/or in | n occurred at vestigation, in | the tir | ma, data end pla opinion, death oc | e, and due | to the cau | ise(s) and m a and place, | anner as stall and due to th | led. he cause(s) |
| - | title of certifier | and manne | or stated. | 0.4 | 29c. I | Licens | se number | | 290 | d. Date signe | d (Month, De | ay, Year) |
| The second secon | | | 2.6 | F1 B | | | | | | | | |
| 1/1 | Ica " | Talle | 111 | 1004 | Cur | 1 | 005 23 | 60 | E | phy | MINU | 6.200 |
| Name and addre | LCQ Bss of person wh | DUL o completed cause | All of death (Item | m 23a) (Type, | Print) | D | 005 27 | 60 | F | ebru | ary | 6,2000 |
| | Facility Name (I) Social Security N 220-18- ual Residence of a. State MD a. Street and Nur 1026 FL. Marital Status 1 Never Marria 3 Widowed (Spec Elementary/Seco Father's Name (A) ABRAHAM Tal. Informant's Name (A) BERNARD Tal. Method of Disp. 1 (X Burial 2 (A) 4 Donation Signature of Fu Signature of Fu Signature of Fu Tal. Part 1. Enter the shock, or head mediate Cause (bease or condition sulting in death) Tal. Part 1. Enter the shock, or head mediate Cause (bease or condition sulting in death) Tal. Other significant in the sulting in death) Was case referencement of the sulting in death) Tal. Other significant in the sulting in death) Was case referencement of the sulting in death) Tal. Other significant in the sulting in death) | Facility Name (If not institution, g Northucest Social Security Number 220-18-9405 ual Residence of Decedent a. State 10b. County MD BALTIM b. Street and Number 1026 FLAGTREE L Marital Status Never Married 2 Married Specify only highest g Specify only highest g Security Number 15 Never Married 2 Married Specify only highest g Security Number 15 Security Only highest g Security Number 16 Specify only highest g Security Number 17 Security Only highest g Security Number 18 Security Only highest g Security Number 18 Security Only highest g Security Number 18 Security Only highest g Se | Facility Name (If not institution, give street and num Nor Huucst Hospital Social Security Number 220-18-9405 In Besidence of Decedent In State 10b. County In BALTIMORE In Street and Number 1026 FLAGTREE LANE Marital Status In Never Married 28 Married In Never Married 29 Married In Heaver Married In Heaver Married 29 Married In Heaver Married | Facility Name (If not institution, give street and number) Nov + Huwes + Hospital Ce Social Security Number 6. Sex 17. Age (In yrs. 220-18-9405 75 ual Residence of Decedent a. State 10b. County 10c. Ci MD BALTIMORE BAI a. Street and Number 1026 FLAGTREE LANE Marital Status 12 Married 12 Married 11 Yes 2 M No If Yes, Give 17 Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ Father's Name (First, Middle, Last) ABRAHAM a. Informant's Name/Relationship (Type, Print) BERNARD I. H. KRAMER / HUSBAND a. Method of Disposition 1 (Reurial 2 © Cremetion 3 Removel from State 4 Donation 5 Other (Specity) Signature of Funeral Service Licensee Ja. Part1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line. Indicated events 1 Indicated | Decedent's Name (First, Middle, Last) VNICE SICH MAN KVAMEV Facility Name (If not institution, give street and number) NON HAWCST HOSPITAL CENTEY Social Security Number 6. Sex 220-18-9405 100. County MD BALTIMORE 100. County MD BALTIMORE 100. County MD BALTIMORE 100. Colly, Town or Lot BALTIMORE 100. City, Town or Lot BALTIMORE 101. Was Decedent Ever in U.S. 13. In June Forces? 11 | Decedent's Name (First, Middle, Last) Facility Name (If not institution, give street and number) Northwest Hospital Center Social Security Number 6. Sex 17. Age (In yrs. last birthday) Months 75. Age (In yrs. last birthday) Months 18. State 100. County MD 10 | Decedent's Name (First, Mickele, Last) PARTING (In not institution, give street and number) Social Security Number Social Security Number Social Security Number 10. Sex 200-18-9405 Social Security Number 10. Sex 200-18-9405 Social Security Number 10. Sex 200-18-9405 Social Security Number 10. Cent of the Sex of the | Personal Policy Control Policy Con | Decedent's Name (First, Middle, Last) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution, give street and number) Feeling Name (First and institution) Feeling Name (F | Decedent's Name (First, Middle, Last) WY WE CE WE WANTE AND STATE AND SHORT | December 1 State of December 2 State of December 1 State of December 2 State of Decemb | December 1 Name (First, Media, Last) WARNER Control Assistation, give street and runshed Name Name Control Assistation Name Name |

State Registrar

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Northwest Hospital Center 5401 old Court
Poad Randallstown,
Maryland 21133



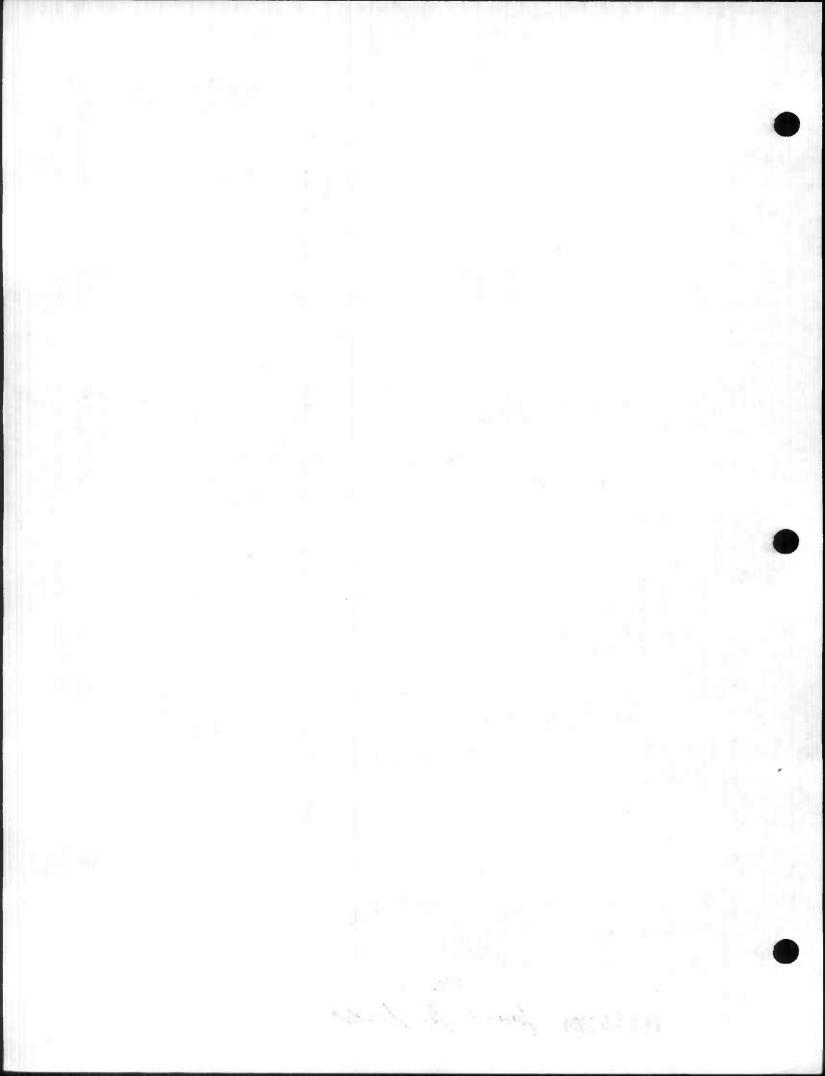
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State of Maryland / Department of Health and Mental Hygiene

| 1. Decedent's | Name (First, Mid | | | 77 | DOED | | 2. Date of Dea | | Year | 3. Tima of Death | |
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| | OMONA SOL | | iumber) | | | BALTIMOR | | 4c. County BALT | IMOR | E | |
| 5. Social Section 215–0 | rity Number 1–5657 | 6. Sex 1 1 M 2 □ F | 7. Age (In yrs | s. last birthday) Yrs. | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day OCT. 11 | 9. Bir (, 1916 | | rthplace (State or Foreign Country) | |
| Usual Reside | 10b. Count | ty | 10c. C | ity, Town or Loc | ation | | | | 1 | 10d. Inside City Limits | |
| MD 10e. Street ar | BAL | TIMORE | | BALTIN | ORE | | | | | 1 ☐ Yes 2X No | |
| 10e. Street ar | d Number DMONA SOL | JTH #8 | | | 10f. Zip Code | 21208 | | 0g. Citizen of V | What Cour | ntry? | |
| 11. Marital St 1 ☐ Never 3 🂢 Wido | cedent Ever in Forces? 2 DNo Sive Dates: | ? If Yes, specify Cuban, Mexican, Puerto | | | | | ck, Whita, | can Indian, etc. WHITE | | | |
| | 15. Decede (Specify only high /Secondary (0-12) | est grade completed | d) (1-4or 5+) | 16a. Deced (Give life. D | during most of work | | 16b. Kind of Bu | | | | |
| 17. Father's N | ama (First, Middle | | | KRIEGE | | 18. Mother's Nam | | | 10) | ELFARB | |
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| 20a. Method | of Disposition | 3 Removal from | 20b. | Place of Dispos cemetery, crem | sition (Neme of natory or other pla | ice) | Date | 20c. Location - | City or To | own, State | |
| BALTIMORE HEBREW CEMETERY 2/6/00 REISTERSTOWN, MD 21. Signature of Funeral Script Users and Address of Facility 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD — PIKESVILLE, MD 21. | | | | | | | | | | • | |
| Immediata C disease or corresulting in disease. Sequentially if any, leedin cause. Enter Ceuse (Diseathat initiated resulting in disease. | ndition sath) ist conditions, to immediate Underlying se or injury | a | 10 | 4 | uence of): | Leac d | cert | | | Kyers | |
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| Part tl. Other | Part II. Other and if cant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cau 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 | | | |
| 100 | 1 / | | | - | | | 24a. Was a perfor | an autopsy med? | 8/ | lere autopsy findings vallable prior to completion of cause i death? | |
| | | | | | | | 1 🗆 Y | es 2 No | 1 | □Yes 2□No | |
| examiner | | Hospital: | Thereses of | J50/0 · · · | Ot 20. Ot | her: | th (Check only or | | | Y. 1 | |
| 27. Menner of Death 1 Describe how injury occurred 28a. Dete of Injury 2 Menner of Death 1 Describe how injury occurred 28b. Time of Injury 2 Accident Investigation 3 Sulcide 6 Could not be detarmined described by the state of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred | | | | | | | | | | | |
| 29a. Certifier (Check o | 1⊠ Certify | ing Physicien: To the | ne best of my kn basis of axamin | lowledge, deeth | occurred et the ti estigation, in my | ime, date and plece, opinion, deeth occur | and due to the d | euse(s) and m | enner es s and due t | stated. to the cause(s) | |
| 29b. Signatur | and titla of parti | tuem | lea | | I | se number 010613 | | 29d. Date signe | | | |
| | address of perso L PEREZ- | n who completed car -MERA | | | Print) TERSTOWN | N ROAD | BA | LTIMORE | , MD | 21208 | |

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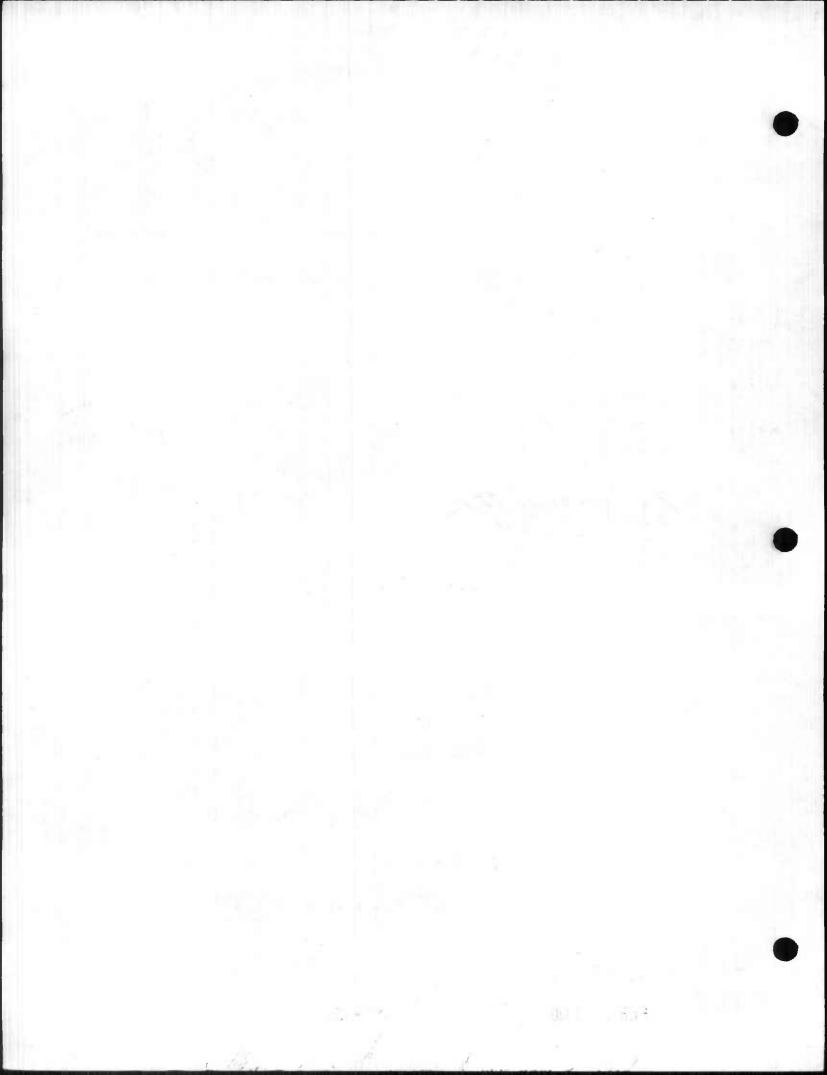
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 13 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** LOLA P. KLEIN FEBRUARY 5, 2000 8:45PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 20F Months Hours 76 Yrs. 088-14-8196 Director JUNE 22, 1923 NEW YORK Usual Residence of Decedent the Marylan r 28a-f show .notified.at 10a. State 10b. County 10c. City. Town or Location 10d. tnside City Limits MD HOWARD COLUMBIA 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 10001 WINDSTREAM DRIVE APT. 802 21044 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 Volume
1 Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married XXMarried Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 QNo Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If them 27 is marked oth lury or other traumatic even Be **JACOB** PERL MARTHA UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (HUSBAND) DONALD KLEIN 10001 WINDSTREAM DR APT 802 COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel ②CCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. BALTO. WASH. CREMATORY 2/7/00 LAUREL, MD 21. Signature of Fune al Service Licenses 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 eelel Part 1. Enter the disease, or complications than paused the diseth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each inn. Interval Between Onset and Death **Physician** tmmediete Cause (Final disease or condition resulting in deeth) /Medical CHRONIC MYELOMENOCYTIC LEUKEMIA 2 YEARS Examiner Due to (or as a consequence of): Physician/Medical Examiner MYELODYSPLASTIC BONE MARROW 3 YEARS use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of). P.0. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC ANEMIA, CHRONIC THROMBOCYTOPENIA, Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed NONHODSKINS LYMPHEMA page 2 certificate 1 Yes 2 XNo 1 Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2XXNo Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division or Attending 5 Pending investigation 1 X Natural 2 Accident s after death. 1 Yes 2 No the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C Hospital **EXCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30573 FEBRUARY 9, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JON K. MINFORD, M.D., 11065 LITTLE PATUXENT PKWY., COLUMBIA, MD 21044 31. Date filed (Month, Day, Year) 32 Registrar's Signatura State FEB 1 0 2000 oaks Registrar



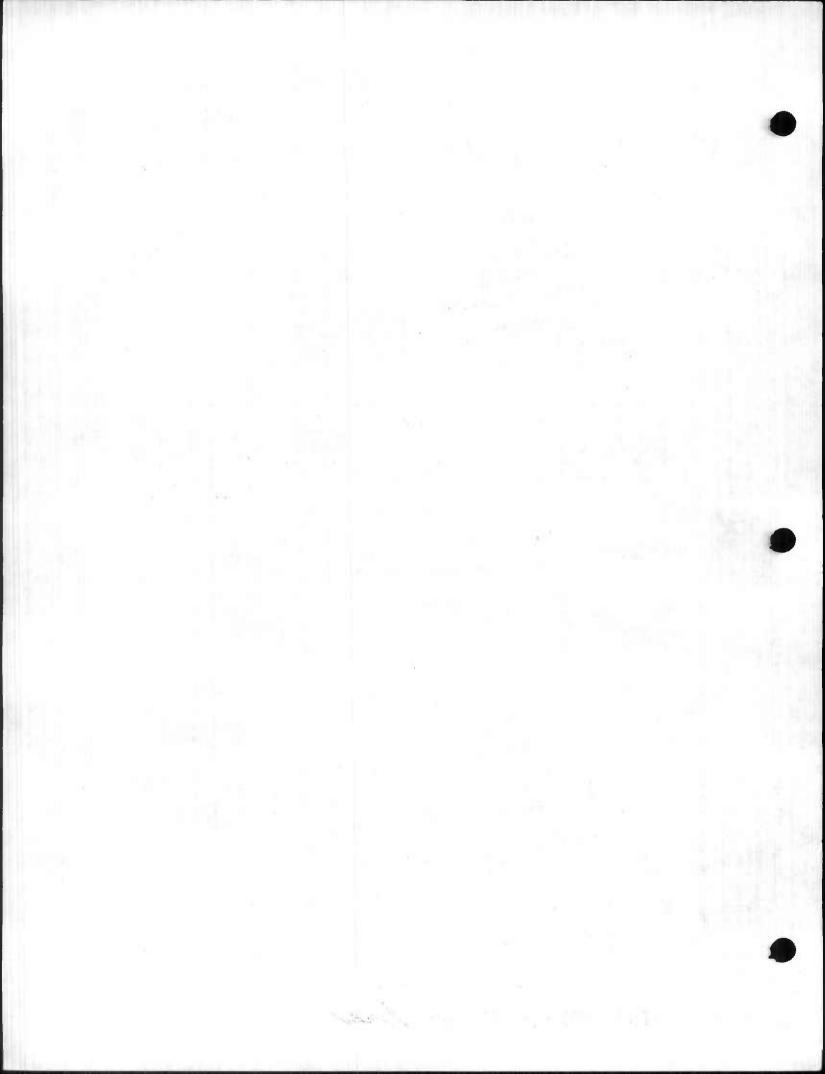
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State of Maryland / Department of Health and Mental Hygiene

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| Usual Residence of Decedent | | 00 | | | | 1.4 | | 7 1313 | 11011 | 101/10 | |
| 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | | | 10 | d. Inside City Limits | |
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| 10e. Street and Number | | | 10f. 2 | ip Code | | | 10 | g. Citizen of V | Vhat Count | y? | |
| 100 I Warwickshii | re Lane | | | 2106 | 1 | | | U.S | | | |
| 11. Marital Stetus | 12. Was Decedent Ev Armed Forces? | rer in U,S. 13. | Was Dec | edent of h | lispanic Origi an, Mexican, | in? (Specif | y Yes or No- | | e - America k, Whita, e | | |
| 1 Never Merried 2 Merried | 1y Yes 2 No If Yes, Give | | | 210 No | | | | Specify | | | |
| 3 Widowed 4 Divorced | Yeer or Detes:W | W.II | | | | | | Opeciny | Wh: | ite | |
| 15. Decedent's Edu (Specify only highest grad | ucation de completed) | 16a. Dece (Give | dent's Us | ual Occup | pation during most od) | of working | 1 | 16b. Kind of Bu | usiness/Indu | stry | |
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| 12th | | Mas | ter | P1um | | - M W | | | Broth | ners | |
| 17. Father's Name (First, Middle, Last) | cank Luhmar | | | | 18. Mother | | esa Mit | laiden Sumam acelt | 10) | | |
| | | | | 400 | | | | | | 21061 | |
| 19a. Informent's Neme/Reletionship (7) Genova Luhman / V | | | | | and Number Shire | | | Burni | | 200e) 21061 | |
| 20a. Method of Disposition | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 20b. Place of Dispo | | | SHILE | - | | 20c. Location - | | | |
| 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F | | cemetery, cre | matory o | other pla | | | | | | | |
| 4 Donation 5 Other (Specify) | | Md. State | | | | | 10/00 | rownsv | irre, | Maryland | |
| 21. Signature of Funeral Service Licens | 500 | 1 2 | 2. Name | and Addre | ess of Facility | Go | once Fu | neral | Home 1 | P.A. | |
| Honna Ma | framero | USA 40 | 001 F | Ritch | ie Hig | hway | Balti | more, 1 | Md. 2 | 1225 | |
| 23a Part1. Enter the disease, or contol shock, or heart failure. List only o | cations that caused the cause on each line | ne death. Do not en | ter the m | ode of dyi | ng, such as c | ardiac or r | espiratory arre | ıst, | | Approximete Intervel Between | |
| | | | | | | | | | | Onset and Deeth | |
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| resulting in death) | D | ue to (or as a conse | quence o | f): | | | | - 5 | | | |
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| Sequentially list conditions, | D | ue to (or es a consec | quence o |): | | | | | | | |
| Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | С. | | | | | | | | | | |
| that initiated events resulting in death) Last | Do | ue lo (or es e consec | quence of |): | | | | | | | |
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| | | | | | | | | | | | |
| Part II. Other significant conditions con | ntributing to death but | not resulting in the u | inderlying | cause giv | ven in Part I. | | 23b. Did to | bacco use co | ntribute 10 | the cause of death? | |
| Caronay arting des | use | | | | | | 1 Y | # 2 □ No | 3 Prob | ably 4 Unknow | |
| | | | | - | | | | | T 041 W | | |
| Sissis | | | | | | | 24a. Was ar perform | | ava | re eutopsy tindings ilable prior to apletion of cause | |
| | | | | | | | | | of d | eath? | |
| Colospens | | | | | | | 1 ☐ Ye | s 2000 | 10 | Yes 2□ No | |
| | | | | | | of Death (| Check only on | 9) | | | |
| 25. Wes case referred to medical axaminer? | Hospitel: | 2 ER/Outpatie | nt 3 🗆 (| JOA | | - | | nce 6 Oth | | | |
| axaminer? 1 ☐ Yes 2 ZONo | - | 28b. Time o | ŧ | 28c. Inju | ry at rk? | 28 | d. Describe ho | w injury occur | red | | |
| axaminer? 1 Yes 2 No 27. Manner of Death | 28a. Dete of Injury (Month, Day) | rear) Injury | | | | lo l | | | | | |
| axaminer? 1 Yes 2 SNo 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Dete of Injury | rear) Injury | M | 10 | Yes 2□N | 0 | | 81. Location (Street and Number or Rural Route Number, | | | |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) tely 1745 1 E Roane MULLAND 2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, giva street and number) BALTINORE BALTIMEN MERCY 1681C If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. lest birthday) Deys M 2DF 213-05-5230 Usuel Residence of Decedent 10a. Sleta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore City Md. N/A 10e. Streef and Number 10f. Zip Code 10g. Citizan of Whet Country? 21206 5603 Greenhill Avenue United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indien, Bleck, White, etc. 11. Maritel Status 1 XYas 2 No If Yes, Giva Yaar or Dalas: 1 Never Merried 2 Merried 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced WII 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Canton R.R. Conductor 18. Mother's Neme (First, Middle, Maiden Surnema) 17. Fether's Name (First, Middle, Last) Thomas P. Mullaney Dorothy Boyle 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Jeanette R. Mullaney (Wife) 5603 Greenhill Avenue Baltimore, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta Parkwood Cemetery 2/11/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21. Signatura of Funarai Sarvice Licensee Milton J Knight Jr 5305 Harford Road Baltimore, Md. 23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco uea contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? 2000 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28d. Describe how injury occurred 27 Menner of Deeth 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

certificate be axec Division of Vital Records, P.O. ŏ Hospital **Physician**

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29b. Signatura and fitting pertifiar

Mc Sernet 32. Registrer's Signature

30. Name and eddress of person who completed cause of deeth (flern 23e) (Type, Print)

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29c. License number

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29d. Date signed (Month, Dey, Year)

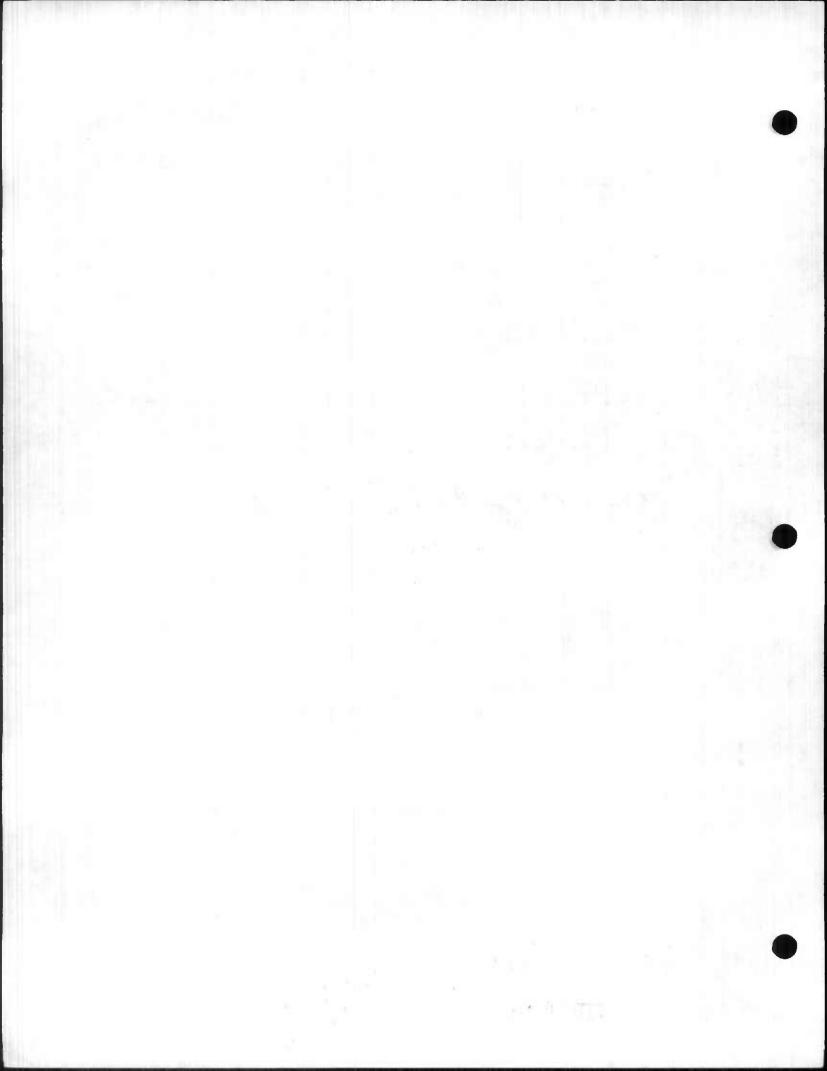
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| | 5. Social Secur 218–22- | -3036 | S. Sex | | e (In yrs. 74 | last birthdey) Yrs. | Months De | | | 925 | 9. Birth | place (State o | Foreign |
| | 10a. State | ce of Decedent 10b. County | | | 10c. Cit | y, Town or Loc | ation | | | | | 10d. Inside Ci | y Limits |
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| 1 | 11. Meritel Ste | tus | 12. V | Ves Decedent B | Ever in U | S. 13. W | es Decedent | of Hispanic Origin? (S | Specify Yes or No- | | | can Indian, | |
| | A | Married 2 Merried | d 1 | med Forces? Yes 2 1 N Yes, Give X Ger or Detes: | No. | | Yes, specify C | uben, Mexican, Puer No Specify: | to Hican, etc.) | Specif | ock, White, fy: Wh | nite | |
| ŀ | | 15. Decedent's Specify only highest | Education grade con | n npleted) | | 16e. Decede | ent's Usual Oc | cupation na duning most of wo tired) | rking | 16b. Kind of B | Business/In | ndustry | |
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| ŀ | | t's Neme/Reletionship | n (Type, F | Print) | | 19b. Meiling | Address (Str | | | r, City or Town | vn, Stete, Zip Code) | | |
| Edward Kelch 1992 Gulfstream Court, Belair, MD 21 | | | | | | | | | | | | | |
| | 20e. Method of | | | | 20b. P | leca of Dispos | ition (Neme of | niace) | Dete | 20c. Location | - City or T | own, Stete | |
| 200 | | I 2 ☐ Cremetion 3 tion 5 ☐ Other (Spe | | vel from State | Fire | st United | l Evangel | ical ch. Cer | n. 2-7-00 B | altimore | , MD | | |
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| | Sequentially life environments of the control of th | st conditions, to immediate Underlying so or injury wents ath) Last significant conditions of the cond | b c d Hospi ston the 28 Physician summiner: | ting to death but ting ting ting ting ting ting ting tin | Due to (co | or as a consequence of as a consequence of as a consequence of a consequen | Jence of): Jence | 26. Plece of De Other: 4 Nursing Injury at Work? 1 Yes 2 No ice | 23b. Did to 1 1 Y 24e. Wes a perfor 1 Y ath (Check only or Nome 5 Resid 28d. Describe h 28f. Location (S City or Tow e, end due to the curred at the time, co | obacco was co | ontribute 3 Pro 24b. V co ontribute 1 ther (Specurred | Vere autopsy valiable prior is ompletion of death? Were autopsy valiable prior is ompletion of death? Were autopsy valiable prior is ompletion of death? Were autopsy valiable prior is one prior is | Deeth Oeeth Oeeth Unknow Indings Oause |
| medical certification: 10 de completes dy mysicialymedical Examinist | Sequentially life environments of the control of th | st conditions, to immediate Underlying so or injury vents sath) Last significant conditions investige of Could no determine the Could no | b c d Hospi ston the 28 Physician summiner: | tal: 1 Inpatie Ba. Dete of Inju (Month, De) Be. Plece of Inju building, etc. | Due to (co | or as a consequence of as a consequence of as a consequence of a consequen | Jence of): Jence | 26. Plece of De Other: 4 Nursing Injury at Work? 1 Yes 2 No ice e time, date end pieceny opinion, deeth occ | 23b. Did to 1 year of the control of | obacco was or real or | ontribute 3 Pro 24b. Very contribute of Ruiner (Special Production of Ruiner as a period of Month) and the distribute of Month and Month a | to the cause obably 4 Were autopsy vailable prior completion of death? Yes 2 with the cause (to the cause (t | of death? Unknow |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Name (First, Middla, | Last) | | ertificate of | | 2. Date of Deat | | | ime of Death |
|-------------------|--|--|--|--|--|-----------------------------------|------------------|--|---|
| /sician | Thomas Michael | McVearry | | | | Month Februar | Day | Yaar | 20 |
| ledical aminer | 4a Facility Name (If not institution, | | | | 4b. City, Town, or Lo | | y 3, 20 | | 00 am |
| mmer | Holy Cross Hosp | | | | Silver Sp | ring | , | | |
| al | | | e (In yrs. last birthda | y) If Under 1 Year | | 8. Data of Birth (Month, Day, | | 9. Birthplace (S Country) | Stata or Foreign |
| | 578-42-6557 Usual Rasidence of Decedent | 10XM 2□ F | 67 Yrs. | Months Days | Hours Min. | April 1 | 3,1932 | Washing | ton, DC |
| ı | 10a. Stete 10b. County | | 10c. City, Town or | Location | | | | | ide City Limits |
| Director | MD Prince | George | Laurel | | | | | 10 | Yas 27 No |
| Ę | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of V | What Country? | |
| | 8901 Eastbourne | Lane | | 20708 | | | USA | | |
| by ruinging | 11. Marital Status 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? d 1 1 1 Yes 2 1 If Yas, Giva Year or Datas: | Ever in U,S. 13 | . Was Decedent of h If Yes, specify Cub 1 ☐ Yas 2 ☐ No | Hispanic Origin? (Spe an, Mexican, Puarto I Specity: | ocify Yes or No- Rican, atc.) | Blac | e - American Ind ck, Whita, atc. :: White | an, |
| Desaiduios | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | Education grade completed) College (1-4or t | 16a. Dec (Gir lifa | edent's Usuel Occup ra kind of work done DO NOT use retire | pation during most of working d) | ng | 16b. Kind of Bu | usinass/Industry | |
| į | 12 | Ø | | nter | | | Governm | ent Pri | t. Ofc. |
| 900 | 17. Fathar's Nama (First, Middla, Li | ıst) | | | 18. Mothar's Nema | (First, Middla, A | Maiden Surnam | na) | |
| 0 | Michael McVearry | 7 | | | Catherine | e Farley | 7 | | |
| | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Ma | iling Addrass (Street | t and Number or Rura | I Routa Number | City or Town, | Stata, Zip Coda, | |
| | Kathleen McVeari | ry/Wife | 8901 | Eastbour | ne Lane, | Laurel, | Maryla | nd 20708 | 3 |
| | 20a. Mathod of Disposition | | 20b. Place of Dis | position (Nama of ematory or other pla | ice) | | | City or Town, St | |
| | 1 Surial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe | | Resurred | ematory or other pla tion Ceme | tery 2 | /10/00 | Clinto | n, Maryl | and |
| | 23a. Part f. Entar tha disease, or conshock, or heart failure. List or Immediata Causa (Final disease or condition resulting in death) | Respira | tory Failu Due to (or as a consistial fibr | 7601 San ntar tha mode of dyi | ineral Homo idy Spring ng, such as cardiac o | Road, I | Laurel, | Appro Interv Onse | oximate el Batween t and Death 2 Weeks |
| ı | Sequentially list conditions | U | Dua to (or as a cons | | | | | 1 y | sal |
| | Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury | | ell Lung (| | | | | 7 M | nths |
| | Cause (Disease or injury that initiated events resulting in death) Last | Ç | Due to (or as a cons | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| | Part II. Other significant condition | contributing to death b | ut not rasulting in the | underlying cause gi | ven in Part I. | 23b. Did to | bacco use co | ntribute to the c | euse of death? |
| | Cardiovascular | disease-Acu | te myocar | dial infac | cation | 1 🗆 Y | es 2 No | 3C Probably | 4 Unknown |
| | | | | | | 24a. Was a perform | | 24b. Were au available completi of death? | prior to on of cause |
| | | | | | | 1 □ Y€ | s 2/ No | 1 🗆 Yas | Xº□ No |
| | 25. Was case referred to medical axaminar? | | | | 26. Place of Death | (Check only on | (8) | | |
| | 1 ☐ Yas 2 ☒ No | Hospitat: 1X Inpatie | ent 2 ER/Outpati | ent 3LI DOA | her: 4 Nursing Hor | ma 5 Raside | ence 8 🗆 Oth | ar (Specify) | |
| | 27. Mennar of Death 1 Neturel 5 Pending 2 Accident investiga | | y Year) 28b. Time tnjury | Wo | ryat irk?]Yas 2 □ No | 28d. Describe ho | ow injury occur | red | |
| | 3 Suicide 6 Could no determin | | ury - At homa, larm, : c. (Specify) | street, factory, office | 3 | 28f. Location (St City or Town | | per or Rural Rout | e Number, |
| | | Physician: To the best caminer: On the basis of and manner sta | axamination and/or | | | | | | ause(s) |
| | 29b. Signatura and tales certifier | | 7 | 29c. Licens | se number | 2 | 9d. Data signe | d (Month, Day, Y | ear) |
| | 2 % | n // | 11 | | | | 10.15 | | |
| | 30. Nums and addrass of person wh | no completed cause of d | eath (Item 22s) (Time | D3599 | 16 | 1 2 | 2/3/200 | 0 | |
| | Linda Burrell, | | | | #210, Si | lver Spr | ing. M | D 20902 | |
| | 31. Date filed (Month, Day, Year) | | ar's Signature | 1 | | T. | 0. | | |
| tate | | | To de la | 17 18 1 | 2.12 c. 11 a d | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dele of Death 3. Time of Death Month Year **Physician** Marie Theresa Mannel :55pm February 8, 3000 cation of Deeth /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner Center | historians | Hunder 1 Year Kasedale Bo If Under 24 Hrs. Hours Min. 8. Dele of Birth (Month, Dey, Year) March 27,1911 Baltimore Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 204 88 213-03-6671 Maryland Director Usual Residence of Decedent the Maryland 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits Hygiene. other than "natural", or frama 23a or 28a-f ahow rent, the Medical Examinar must be notified at 1 Yes 2 No Director Rosedale Baltimore Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 21237 United States 930 Chesaco Avenue Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Slatus Bleck, White, etc. flied within 72 hours efter 1 Yes 25 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p **3** Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Seamstress Tailoring 11 Years 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Peges 1 and 2 should be nent of Health and Mentel (Not Known) Mary Charles Soul 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) permit. Peges 1 and 2 sh Department of Health and important: If Item 27 is m any injury or other treum Rosedale, Maryland 21237 Mr. Robert J. Mannel (Son) 930 Chesaco Ave. 20b. Place of Disposition (Neme of 20a. Malhod of Disposition Deta 20c. Location - City or Town, Slete tery, cremetory or other piece) A Burial 2 ☐ Cremetion 3 ☐ Removel from State 2/10/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Due to (or es e consequance of): Examiner sician end buriel-transit Irosepsis The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Lesl Due to (or es e consequence of): physician s the buriel Box 68760. Physician/Medical Due to (or es e consequence of): been signed by the a should be deteched for Part II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes en autopsy performed? 24b. Wera autopsy findings aveilable prior lo Completed completion of cause of death? page 2 20 No 1 Yes 1 Yas 2 No of Vital Attending Physicien: director. 25. Wes casa referred to medical examiner? 8 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Pending investigation 24 hours after death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledga, daeth occurred et the tima, data and place, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only onel within 2 \$ 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) he 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

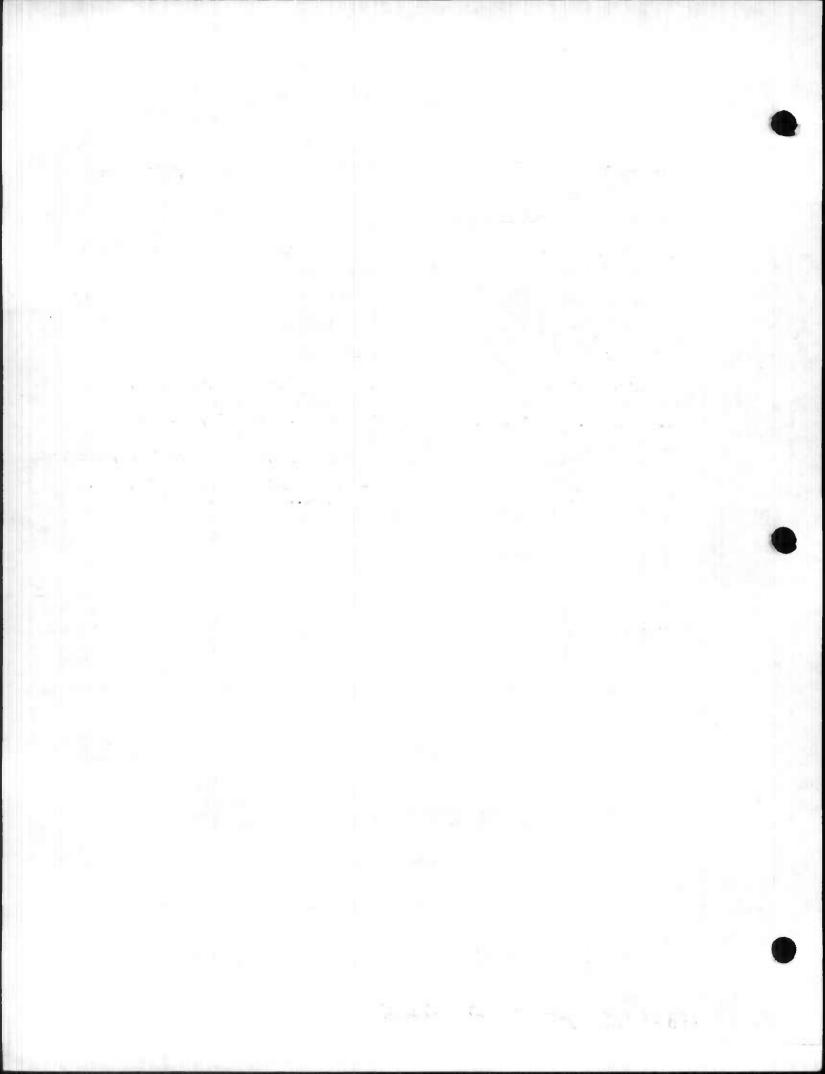
Registrar

Dr Sheena 31. Dete filed (Month, Day, Year)

1 0 2000

32. Registra/s Signeture

Kenne 9000 Franklin Square Drive Baltimore Maryland 2123



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month Gladys McCrank 5:40 pm February 7, 2000 Franklin Square Hospital Center 6. Sex 7. Age (In yrs. last birthday) If Under Months 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-7-18 Birthplace (State or Foreign Country) 451-18-4375 Days Hours 1□ M 20XF Missouri **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Rosedale 1 ☐ Yes 🎾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Parham Cr. Apt. TD 21237 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ^X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Methias Wilson Anna Rebecca King 19a. Informant's Neme/Reletionship (Type, Print) Joseph D. McCrank / husband 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10 Parham Cr. Apt. TD Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1♥ Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Gardens of Faith 2-10-00 Baltimore, MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Euneral Service Licenses 1211 Chesaco Ave. Rosedale, MD 21237 enusi 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death with. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finel disease or condition resulting in death) Ischemic Bowe Stage Kena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 1) Netural 2 Accident 5 Pending investigation

1 Yes 2 No

29c. License number

RD198762

lician and burial-transit The lew requires that the deeth certificate be axecuted physician s the buria Box 68760. P.O. | Records. pege 2 of Vital this funeral After

Physician

/Medical

Examiner

MD

Director

Funeral

p

Completed

Funeral

Director

288-1

ò

flied within 72 hours after death with hygiene.

Physiene "natural", or flems 23e ent, the Medical Examinar must b

Pages 1 and 2 should be nert of Health and Mental

Department of Health a Important: If Ilam 27 is any injury or other tra 2008.

Physician

/Medical

Examiner

Sladys MC Crank Baltimore, Maryland 21215-0020

Physician/Medical Examine þ Completed or Attending Physician: 8 Medical Certification: To Division To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After completely filled in by the fun

Registrar

DHMH 16 Rev 6/95

State

Anita 31. Date filed (Month, Day, Year) FEB 1 0 2000

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certified

6 Could not be

Philip N.D. 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Philip 9000 Franklin Square Drive Baltimore Moryland 21237

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

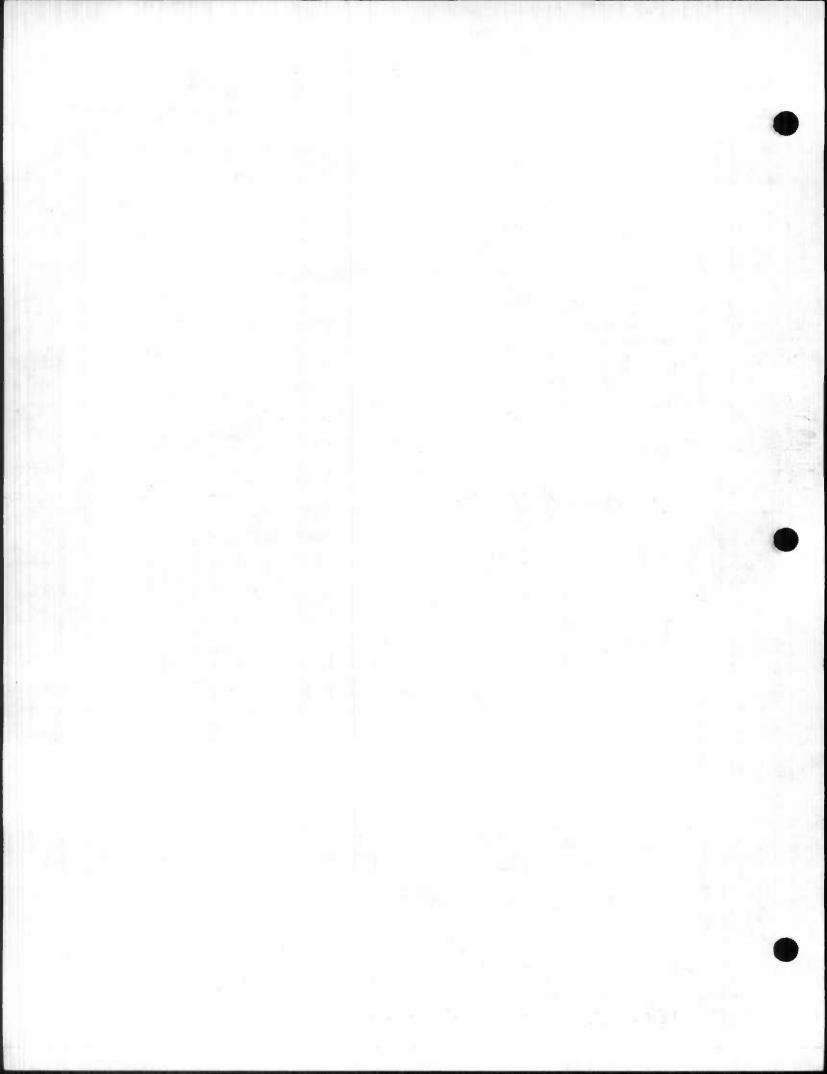
ORIGINAL

1) Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

tebruary 7,2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DeyrH FEBRUARY 8:35 Pm ELLIHU NORRIS 2000 06 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Randallstown Northwest Hospital 8. Dete of Birth (Month, Day, Year) Dec. /, 1910 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 109–26–2907 If Under 24 Hrs. Birthplace (State or Foreign Country) XXM 20 F Hours Ga. **Usual Residence of Decedent** 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County Baltimore 1 Yes 2 No Md. Lochearn 10s. Street and Number 3623 Bellmore Road 10g. Citizen of What Country? 10f. Zip Code 21244 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ₽ No Black, White, etc. 1 Never Married 2 Married **Black** 1 ☐ Yes 2 ☐ Specify: Specify: If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Educator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Luke Norris Mattie Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine L. Hooper Foster 5106 Wesley Avenue Baltimore, Md. 21207 Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Md. National Memorial Park Feb. 14 Laurel, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Light 22. Neme and Address of Facility Nutter Funeral Homes, 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS. disease or condition resulting in death) Due to (or as a consequence of) BILATERAL A INDMUSING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLE ROTIC DISEASE. CARDIOVASCULAR 24b. Were eutopsy lindings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 Yes 2 No t ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify)

physician and the burlat-transit The law requires that the death certificate be executed Box 68760 P.0. been signed by the a should be detached Records, page 2 certificate of Vital Division

Physician /Medical

Examiner

Examiner

Physician

/Medical

Examiner

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Funeral

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Director

the Maryland

permit. Pages 1 and 2 should be filled within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiene. Important: if New 27 is marked other than "natural", or Nems 23s or 28a-f show with Injury or other traumatic event, the Medical Examinar must be notified at page.

Baitimore, Maryland 21215-0020

Physician/Medical þ Completed 8 Certification: To

al or Attending Physician: The safer death.
It Director: After this certificated in by the funeral director, pages. filled in To the Hospital of Within 24 hours at To the Funeral D completely filled Medical

Registrar

31. Date filed (Month, Day, Year) State

4 Homicide

29b. Signature and title of certifier

29a. Certified

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pisce, and due to the cause(s) and manner stated.

D 42723.

29c. License number

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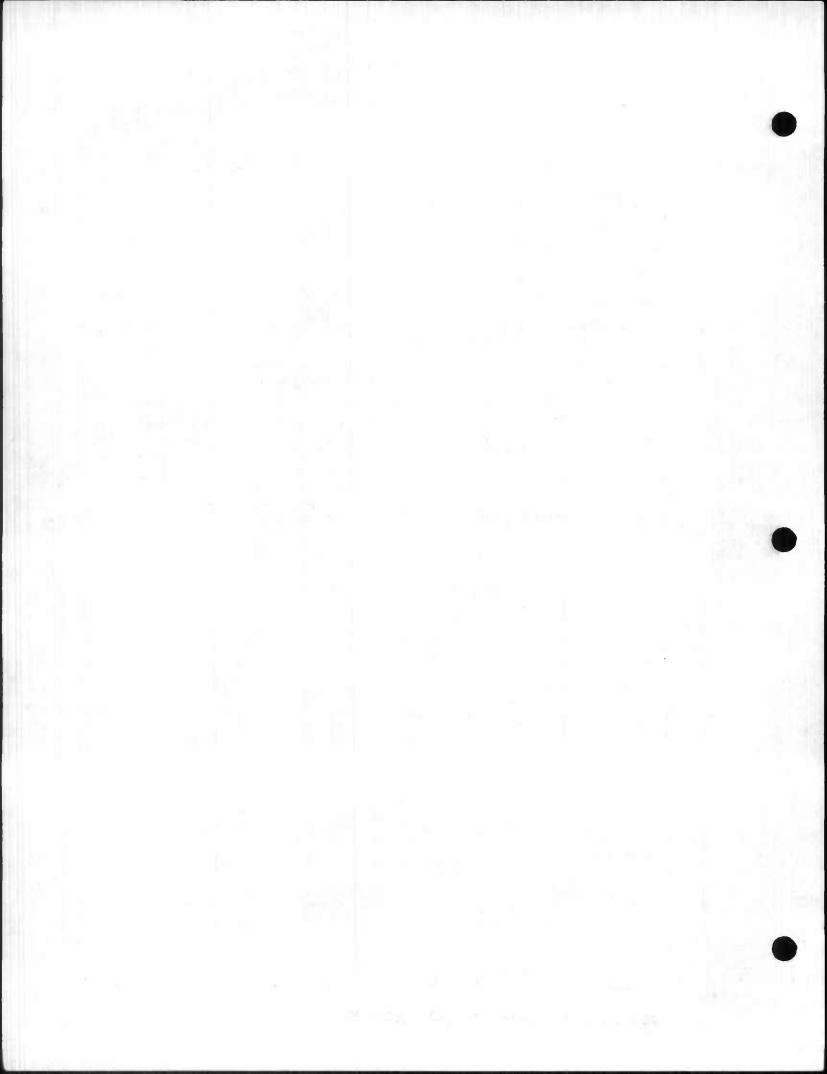
30. Name and address of person who comple of death (Item 23a) (Type, Print) IFARISH. VVERAHALLI

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HOSPITAL

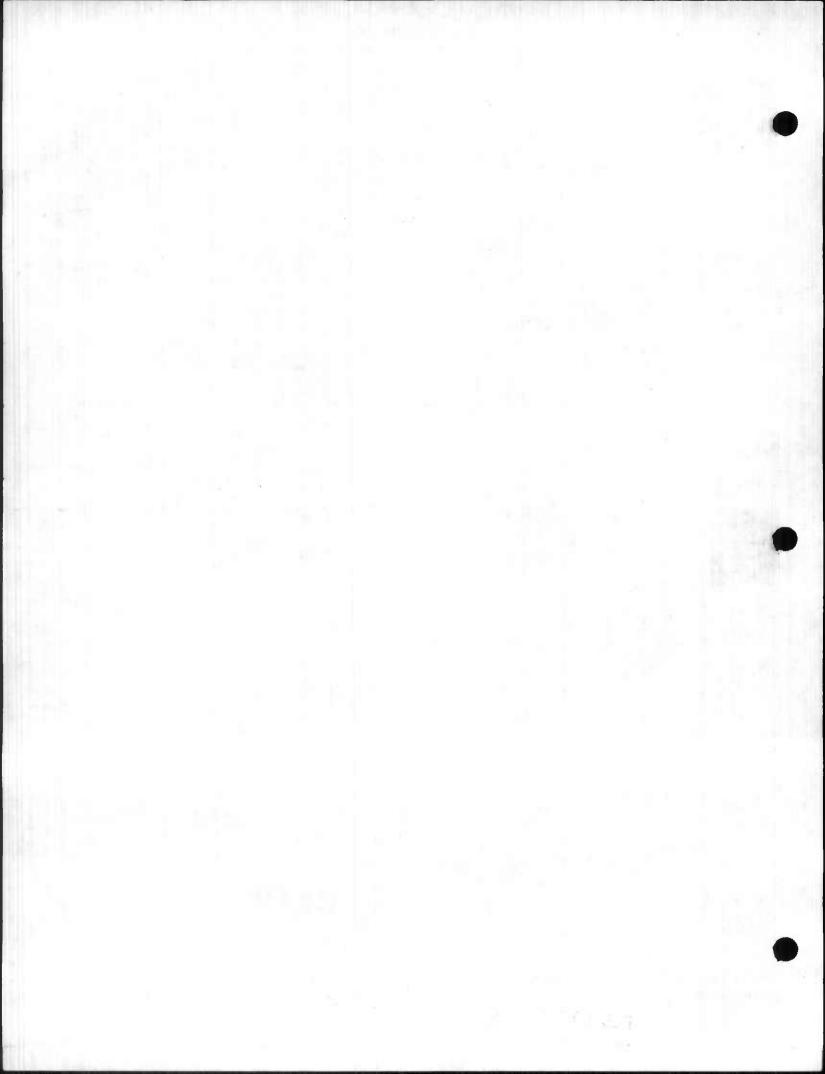
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32. Registrar's Signature FFR 1 0 2000



| December Physician TADEUS NIEWIEROWSKI 2 Date of Death Day Year 1928 PM 1928 P | 00-0665 | -510 | | State of Maryl | and / D | | Health and | Mental Hyg | | 0 | 04045 |
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| 1 1 | 23 w | Ta. | 406 S. PATTE | RSON PARK A | AVE. | 2 | 1231 | | POLA | ND | |
| Beautiful State Construction C | | - Pu | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | n U,S. | 13. Wes Decedent of | Hispanic Origin? (Suban, Mexican, Puer | pecify Yes or No- o Rican, etc.) | | | |
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| Physician // Medical Examiner Physician // Medical Examiner // Medical Exam | Semit. | | 2t. Signature of Funeral Service Lice | 600 P | 1 | 22. Name and Add KACZORO | ress of Facility WSKI FUI | NERAL HO | OME P. | Α. | |
| Physician (Medical Examiner) Part Compared Compa | 40100 | | Cugue | (auto) | h | 1201 DU | INDALK A | JE. BAL | ro., M | D. | 21222 |
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| 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33. Registrar's Signature 29a. Certifier (Check only one) 1 | this aldi | | | 1 LI Inpatient | | Mileni 3LI DOA | 4 Li Nursing r | | | | (h/) |
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| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mannar as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 5, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mannar as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TEBRUARY 5, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The person of the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated. 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature | after da Direct d in by | Sertific | | 288. Placa of Injury - A | t home, fam ecify) | n, street, factory, offic | 0 | | | er or Rur | al Route Number, |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) White Many Day (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature of Many Land 21201 | n 24 houn n 24 houn ne Funere plataly fille | | (Check only YX Medical Exam | niner: On the basis of exam | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) White Many Day (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature of Many Land 21201 | within To th | | 29b. Signature and title of certifier | 1 | | 29c. Lice | nse number | 2 | 9d. Date signe | d (Month, | Day, Year) |
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| State Registrar State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 Aports | 0 | | 1111 | | | enn Street | | re, Mary | land 21 | 201 | |
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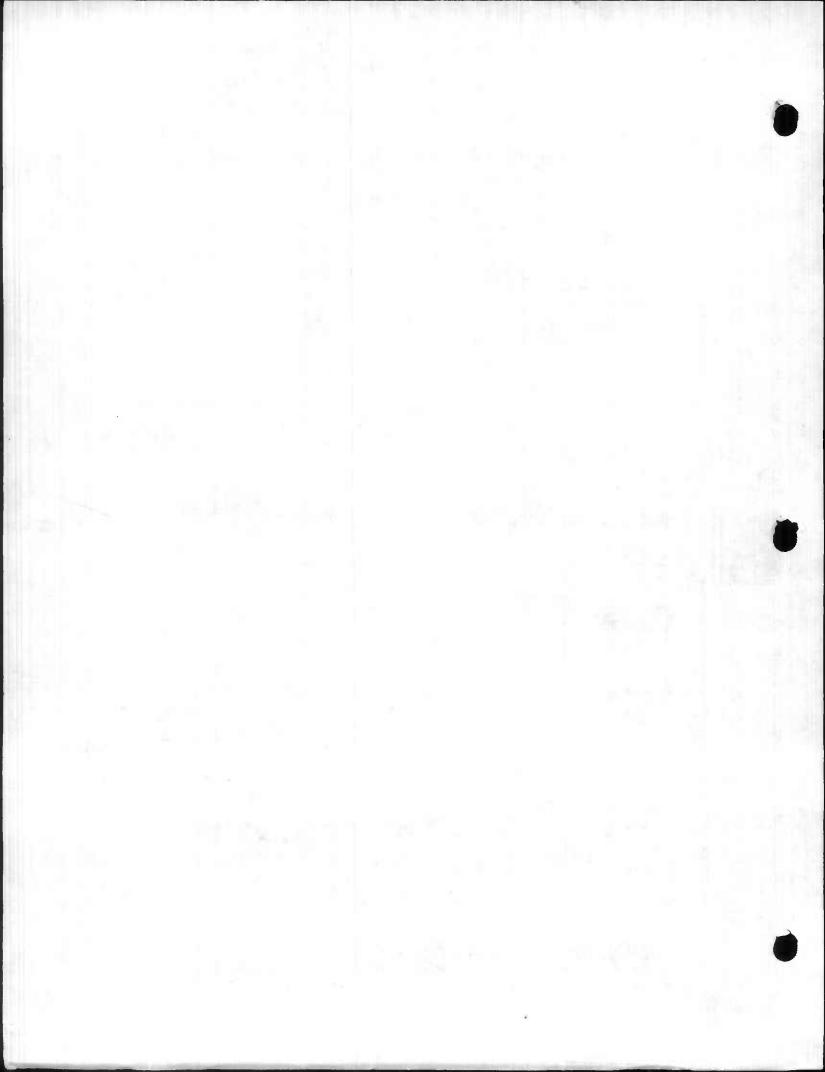


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| Security Number 3-42-6588 esidence of Decedent ite 10b. County rland N eet and Number 3213 Esthe tal Status Never Married 2 Marr Widowed 4 Divorced 15. Decedent (Specify only highes entary/Secondary (0-12) 9 er's Name (First, Middle, Larence Os ormant's Name/Relations is sell Osbo thod of Disposition Burial 2 Germetion IDonation 5 Other (S) maker of Funeral Service Lawrid A | A r Place 12. Was Dec Armed For 11 yes, Giryear or Electron st grade completed) College (Last) borne hip (Type, Print) rne, Jr 3 □ Removal from pecify) | 5 4 10c. C 1 | Yrs. Ity, Town or Lo J.S. 13. 16a. Decer (Giva iffa. iffa. iffa. 19b. Mailin 31 (Place of Dispo | Months I Control of Months | ltij ode 1122 nt of Hir r Cuba No Occupir | If Under 24 Hr. Hours Mir LMOre 24 ispanIc Origin? (c., Maxican, Pua Specify: ation during most of well) 18. Mothar's Na Jes and Number or F alls Ct | Specify Yas or Nov 16 Specify Yas or Nov 16 | 10g. Citizen of 10g. Citizen of 14. Recalled Specific Specific Country 16b. Kind of B Country Hall | 9. Birthplaca (State or Foreign Country) Maryland 10d. Inside City Limits 12 Yes 2 No What Country? USA ce - American Indian, ck, White, atc. 9: White susinass/Industry try Club ma) 1, State, Zip Code) MD 21236 |
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| (Specify only highes entary/Secondary (0-12) er's Name (First, Middle, Larence Os ormant's Name/Relations is sell Osbo thod of Disposition Burial 2 Scremetion Donation 5 Other (S) Charter of Funeral Service Lawred A | borne hip (Type, Print) rne, Jr | . / Son | 19b. Mailin 31 SPlace of Dispocermatery, cref | oundsl og Addrass (S Stone sition (Nama matory or othe | Street & Fa | eper 18. Mothar's Na Jes and Number or F alls Ct | ama (First, Middle Sie Mo Bural Routa Numi Perr | Coun: e, Maiden Sumat ore ber, City or Town y Hall | try Club na) , State, Zip Code) , MD 21236 |
| eritary/Secondary (0-12) 9 er's Name (First, Middle, Larence Os ormant's Name/Relations 5 sell Osbo thod of Disposition Burial 2 Gremetion Donation 5 Other (S) Common of Co | College (Last) borne hip (Type, Print) rne, Jr 3 □Removal from pecify) | . / Son | 19b. Mailin 31 S | oundsl oundsl og Addrass (S Stone sition (Nama matory or othe | Street & Fa | eper 18. Mother's Na Jes and Number or F alls Ct | ama (First, Middle Sie Mo Bural Routa Numi Perr | ore ber, City or Town y Hall | , State, Zip Code) |
| larence Os ormant's Name/Relationsis sell Osbo thod of Disposition Burial 2 Gremetion Donation 5 Other (S) Donation Donation Common Edward A Intil Enter the disease or. | borne hip (Type, Print) rne, Jr 3 □Removal from pocity) | Stata 20b. | 19b. Mailing 31 September 19b. Mailing 31 Se | ng Addrass (S Stone sition (Nama matory or othe | Fa of prince | 18. Mother's Na Jes and Number or F alls Ct | sie Mo dural Route Numi Perr | ore ber, City or Town y Hall | , State, Zip Code) , MD 21236 |
| ormant's Name/Relations is sell 0sbo thod of Disposition Burial 2 Differention Donation 5 Other (S) Date of Funeral Service Lawred A Edward A Inter the disease of | hip (Type, Print) rne, Jr 3 □Removal from pecify) | Stata 20b. | 31 S Place of Dispo cemalery, cres tro Cr | Stone sition (Nama matory or other cemato | of or place | and Number or F alls Ct | . Perr | ber, City or Town y Hall | , MD 21236 |
| ssell Osbo thod of Disposition Burial 2 Dicremetion Burial 3 Dicremetion Burial 4 Dicremetion Burial 5 Dicremetion Burial 6 Dicremetion Burial 7 Dic | rne, Jr | Stata 20b. | 31 S Place of Dispo cemalery, cres tro Cr | Stone sition (Nama matory or other | of or place | alls Ct | . Perr | y Hall | , MD 21236 |
| Burial 2 Cremetion Donation 5 Other (S) D | pecify) | Stata | cematery, cres tro Cr | ematory or other | er plac | | | 20c. Location | - City or Town, Stata |
| Edward A | Jugoro | lik | | | | . Inc. | 2/9/00 | Balti | imore, MD |
| rt1. Enter the disease, or | | chik | | remat 299 Fr | Addres | ss of Facility n Soci | ety of | MD, Ir | nc. |
| ock, or heart failure. The failure the Cause (Final or condition g in death) | | T VENTR | ICULAR | _ | ASI | S OF HEA | ART | | Intarval Batween Onset and Death |
| tially list conditions, eading to immediate Enter Underlying | f b | Due to (| or as a consec | uence of): | | | | | |
| ated events | с | Due to (| or as a conseq | uence of): | | | | | 1 |
| | | leath but not re | sulting In the u | nderlying cau | sa give | en in Part f. | | | ontributa to the cause of death? |
| IRRHOSIS | | | | | | | | | 24b. Wara autopsy findings available prior to completion of cause of death? |
| 196 | | | | | | | 1X | Yas 2□No | 1. Yas 2□ No |
| niner? | Hospital- | | | | Othe | or. | | | |
| | 28a. Date | of Injury | 28b. Time of | | | 4 LI Nursing | 1 | | |
| Accident investig Suicide 6 □ Could r | pation not be one Disease | | | М | 10 | | 28f Location | (Street and Num | her or Burel Boule Number |
| dotom | | | | oot, rectory, 0 | ипси | | | | or man route number, |
| eck only 2 Medical I | Examiner: On the b | asis of axamin | | | | | | | |
| S HILL SA | Continue and title of certifier and title of | Ther algnificant conditions contributing to depend on the condition of the conditions o | d | d | d. Composition Condition Contributing to death but not resulting in the underlying cause Contributing to death but not resulting in the underlying cause Contributing to death but not resulting in the underlying cause Contributing to death but not resulting in the underlying cause Contributing Contributi | d | d. Compared to the state of | d. Comparison of the conditions contributing to death but not resulting in the underlying cause given in Part f. Comparison of the conditions contributing to death but not resulting in the underlying cause given in Part f. Comparison of the conditions of th | Differ significant conditions contributing to death but not resulting in the underlying cause given in Part f. Continued Continued |

Radentz
32. Registrar's Signatura
2 2000

M Nact, mp
sof person who completed cause of death (fleer 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day Year **Physician** PLEWACKI 12:48 PM MATRICE 2000 February /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER HOPKINS BAYVIEW BALTIMORE JOHNS BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1□M 2□F Months 218-53-9888 AUG 5, Director North Carolina Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow 1 ☐ Yes 2 No MD Dunda1k Baltimore Director 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23s or 233 Baltimore 21222 USA Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married natural, or altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant. If flam 27 is marked off Be Thelma Porcelli Theodore Roby 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If hem 27 is any injury or other tra-1418 Mariner Drive Arnold, MD 21012 Rebecca Weller/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 02/08/00 Baltimore, MD 21. Signature of Funeral Servicert Rensee Cremation Society of Maryland, Inc. Homos Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · UPPER GASTROINTESTINAL BLEED 24 hours disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner HEPATIL CIRRHOSIS 1)NKNOWN physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. COHOL ABUSE AND DEPENDENCE Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined To the Hospital or Atternation 24 hours after deadle to the Funeral Director completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20314 FERRU ARY 6,2000 G. REDGARE, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (FRAHAM REDGRAVE 4040 EASTER NAVENUE, BALTIMORE, MD ZIZZIL

DHMH 16 Rev 6/95

State

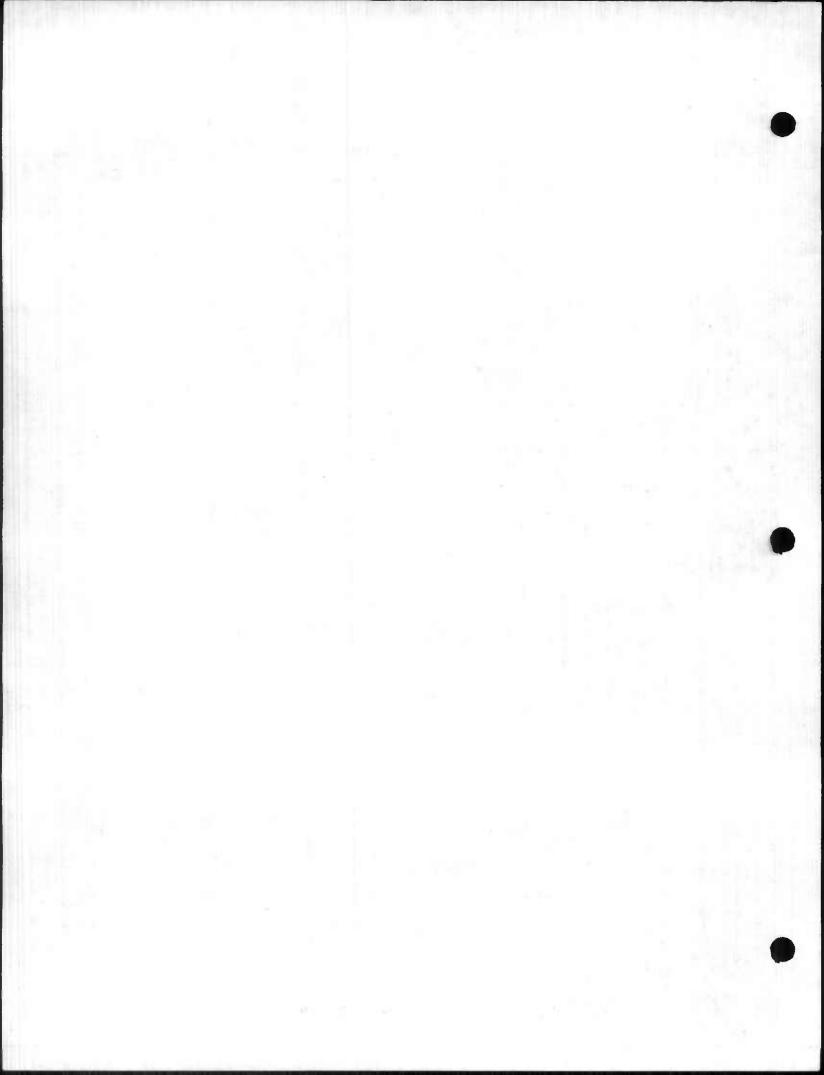
Registrar

31. Date filed (Month, Day, Year)

32. Registraf's Signature

21224

doorth



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

| | # 8 PER F.H. G780 2-1 1. Decedent's Name (First, Middle, I | | C | ertificate of | Deali | | 2. Dete of Dee | | | 3. Time of Death |
|---|--|---|-----------------------|--|--------------|--------------|--------------------------------|-----------------|--------------|---|
| àn | MARIHA W. PAJAK | | | | | F | Month | 1, 200 | Year | 9:00 AM |
| cal ner | 4e Facility Neme (If not institution, g | ive street and number) | | | 4b. City, To | own, or Loc | ation of Deeth | 4c. County | of Deeth | 9:00 An |
| | 1716 PEPPERMINI LA | NE | | | WESI | MINISIE | R | CARR | IL | |
| | 5. Sociel Security Number 6. | | (In yrs. last birthda | y) If Under 1 Year Montha Deys | | r 24 Hrs. | 8. Dete of Birth | h v. Year) | 9. Birthp | placa (State or Foreigntry) |
| | 220-01-5706 | 1□ M 2M7F 78 | _79 Yrs. | | | | 7/307 | 21 | MD | ,, |
| | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Town or | Location | | | | | 1 | Od. Inside City Limits |
| י מיוכומו הוסיסים | MD CARRO | 8_ | | MINISIER | | | | | | 1 ☐ Yes 2 🗷 No |
| | 10e. Street and Number | | MY | 10f. Zip Code | | | | 10g. Citizen of | What Cour | ntrv? |
| | 1716 PEPPERMINI LANE | | | 2115 | 7 | | | USA | | , |
| | 11. Meritel Stetus | 12. Wes Decedent Ev | ver in U,S. 1 | 3. Wes Decedent of If Yes, specify Cul | | rigin? (Spec | city Yes or No- | | e - Americ | en Indian, |
| | 1 Never Married 2 Merried | Armed Forces? 1 ☐ Yes 2 🔯 No | | | | | licen, etc.) | | ck, White, | |
| | 3 ⊠WIdowed 4 □ Divorced | If Yea, Give Yeer or Detes: | | 1 □ Yea 2 No | Specify | ' : | | Specif | Y: WHITE | E |
| | 15. Decedent's | Educetion | 16a. Dec | cedent's Usuel Occu | pation | et of workin | | 16b. Kind of B | usiness/Inc | dustry |
| | (Specify only highest (Elementery/Secondary (0-12) | College (1-4or 5+ | life | ve kind of work done . DO NOT use retin | ed) | St Of WORKIN | 9 | | | |
| | 6 | 0 | | FACIORY WOR | KER | | | WESTINGH | USE | |
| | 17. Fether's Neme (First, Middle, La | st) | | | 18. Moth | er's Neme | (First, Middle, | Maiden Sumer | ne) | |
| | ANDREW WLODARCZY | ζ | | | MARY | R AVA | NIACH | | | |
| | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, 2 1716 PEPPERMINI' LANE WESIMINISIER, MD. 21157 | | | | | | | | | |
| | MRS. MARYANNE COFFLI | 1 / DAUGHIER | | | LANE WE | SIMINU | 1 | | | |
| 17. Fether's Neme (First, Middle, L ANDREW WICDARCZ) 19e. Informent's Neme/Reletionsh MRS. MARYANVE COFFIL 20e. Method of Disposition 1 Method of Disposition 1 Method of Disposition 20e. Method of Disposition 21. Signature of Funeral Service L | | ☐Removel from State | cemetery, c | position (Name of remetory or other pla | асе) | i | Dete | 20c. Location | - City or To | own, Stete |
| | | city) | HOLY ROSAR | Y CEMETERY | | 4/2000 | | dundalk, | MD. | |
| | | en | 1 | 22. Neme end Addr | | | א ס | | | |
| | Lugar /6 | 201 | | 1201 LINDALI | K AVE | PATITI | MORE. MA | RYLAND 21 | 222 | |
| | 23a. Pert1. Inter the diese is, or co shock or heert fail in List on | mptications that caused to | ne deeth. Do not e | enter the mode of dy | ing, such as | s cerdiec or | respiretory ar | rest, | | Approximete Intervel Between |
| | 6 | | | | | | | | 1 | Onset end Death |
| | Immediate Cause (Final disease or condition | Colon Ca | ncer | | | | | | | Years |
| | resulting in deeth) | D | ue to (or es e cons | sequence of): | | | | | | |
| | | b | | | | | | | | |
| | Sequentially list conditions, if any, teading to immediate | D | ue to (or es a cons | sequenca of): | | | | | | |
| | Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | c | | | | | | | 1 | |
| | resulting in deeth) Last | D | ue to (or es e cons | equence of): | | | | | 1 | |
| | | d | | | | | | | | |
| | Part It Other significant conditions | contribution to don't but | not requiting in the | undarhing cours | iven in Bod | 1 | 23h Did | tohacco usa or | meribuse s | o the cause of deati |
| | Pert It. Other significant conditions | Commouning to death but | not resulting in the | andenying ceuse g | Net in Per | 1. | | | | bably 4 Unkno |
| | | | | | | | | 2010 | 0_110 | bably 4EXONANO |
| | | | | | | | 24e. Wes | en autopsy | 24b. W | ere autopsy findings |
| | | | | | | _ | perio | rmeu r | of | railable prior to impletion of cause death? |
| | | | | | | | 101 | Yes 2 No | 1[| □ Yes 2 No |
| - | 25. Wes case referred to medical | | | | 26 Piac | e of Death | (Check only o | | | |
| | exeminer? 1 ☐ Yea 2 No | Hospitel: 1 Inpatien | 2 ER/Outpet | ient 3 DOA | ale a se | | | denca 6 □Ot | her (Speci | (v) |
| medical columnation: 10 | 27. Menner of Death | 28a. Dete of Injury (Month, Day | | of 28c. tnj | | | | how injury occu | | 77 |
| | 1 Neturet 5 ☐ Pending 2 ☐ Accident Investiget | | Year) tnjur | | Yes 2 | No | | | | |
| | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | | y - At home, ferm, | street, fectory, office | 9 | 2 | 8f. Location (S City or Tov | Street and Num | ber or Rur | al Route Number, |
| 1 | 4 Ditionicide | building, etc. | (эрвсну) | | | | Only of Tol | wii, Otoloj | | |
| | 29e. Certifier (Check only 2 Medical Ex | Physician: To the best of amtner: On the basis of e | my knowledge, de | eth occurred et the i | time, date e | nd plece, a | nd due to the | ceuse(s) and m | enner as a | stated. o the cause(s) |
| 0 | one) | end menner stete | ed. | | | | | | | |
| | 29b. Signeture end title of certifier | | | | nse number | | | 29d. Dete sign | | Day, Year) |
| | 200 | | | ml | 045 | 570 | | 2/3/2 | 0 | |
| | 30. Name and address of person wh | o completed ceuse of dec | oth (ttem 23a) (Typ | e, Print) | 0.10 | | | | | |
| | Glenn Herman, | м.р., 138 | U Progr | ess Way | Suit | e112 | , Elde | ersbur | g, M | D 21784 |
| | 31. Date filed (Month, Day, Year) | 32. Hegistrer | s Signature | Sport | | | | | | |
| ır | EED 7 () 2 | ODD Dens | ~ | 1000 | April 1 | | | | | |

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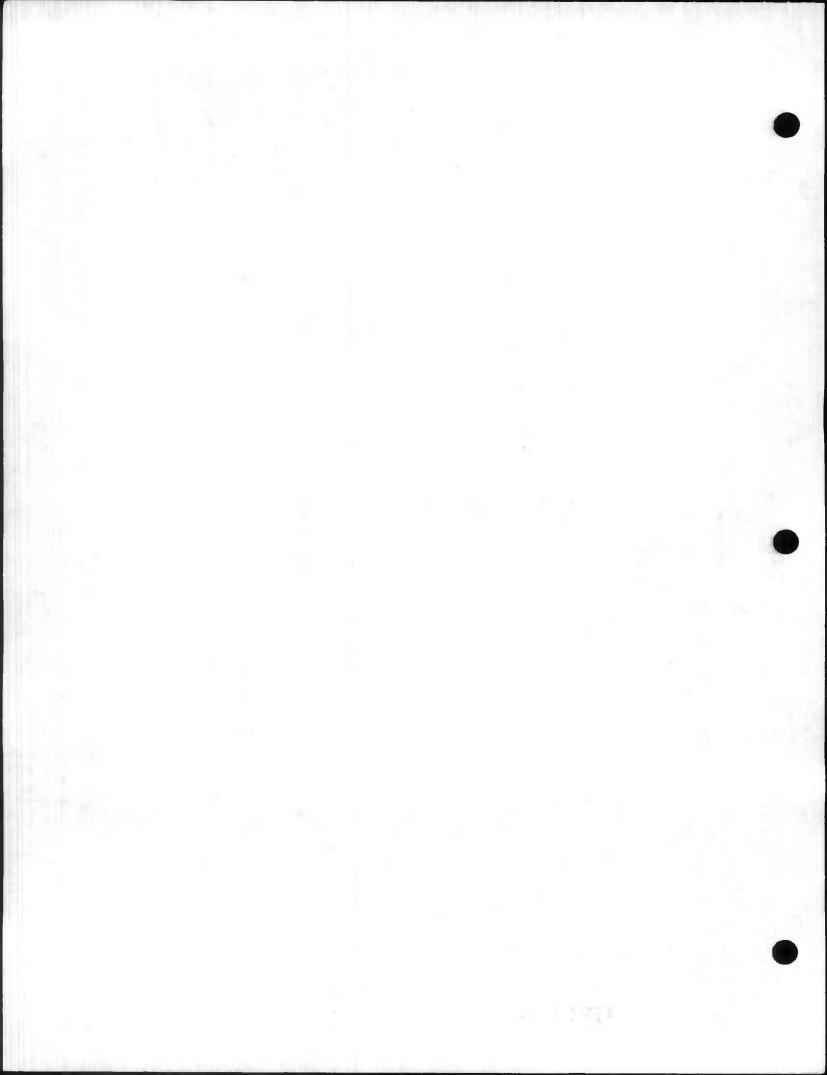
ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

| | | | | Ce | rtificate of | Death | Re | g. No. | 1 04049 |
|----------------|---|--|--|----------------------------|--|---|--|------------------------|--|
| | Dhuaisina | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of Deeth | | 3. Time of Death |
| | Physician /Medical | Peter Paicos | 4-1 | | | | February | 7^{Day} , 200 | 5:05 pm |
| À. | Examiner | 4a Facility Name (If not institution, give | e street end number) | | | 4b. City, Town, or L | ocation of Death | 4c. County of | Death |
| 110 | | Cherry Lane Nurs | | | | Laurel | | | e George |
| | Funeral Director | 5. Social Security Number 6. S 022-05-9675 Usual Residence of Decedent | Sex 7. Age (In 92 | yrs. last birthday Yrs. | If Under 1 Year Months Days | | 8. Date of Birth (Month, Dey, Sept. 30 | Year) 9, 1907 1 | Birthplace (State or Foreign Country) Massachusetts |
| | E S E | 10a. State 10b. County | 10c | . City, Town or L | ocation | | | - 12 | 10d. Inside City Limits |
| | Many At sh Bed a | MD Howard | | Laurel | | | | | 1 ☐ Yes 2X No |
| į. | irec in | 10a. Street and Number | | Dagier | 10f. Zip Code | | 10 | g. Citizen of Who | at Country? |
| | M M M M | 9428 Mayflower (| Court | | 20723 | 3 | | USA | |
| 21215-0020 | n 72 hours after death with the Marylar "natural", or hems 23a or 28a-f show edical Examiner must be notified at letted by Funeral Director | 11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: | in U,S. 13. | Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🕱 No | Hispanic Origin? (Sp an, Mexican, Puerto Specify: | ecity Yes or No- Rican, etc.) | Bleck, | American Indian, White, etc. White |
| 9 | 72 ho natur disal | 15. Decedent's Education (Specify only highest gra | ducation | 16e. Deci | edent's Usual Occup | pation during most of work ed) | ina 1 | 6b. Kind of Busin | ness/Industry |
| 21 | led within 72 ho lygiene. her than "naturn it, the Medical E Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retire | ed) | wig | | |
| | Cor Hard | 12 | Ø | Ma | nager | | | Restaura | ant |
| Ž, | 2 20 2 | 17. Father's Name (First, Middle, Last, John Peter Paice | | | | | e (First, Middle, M. | | |
| 2 | marked marked marked marked | | | | | | na Brach | | 7:- 0 - d-1 |
| Maryland | 20年 章 章 | 19a. Informant's Name/Relationship (| Type, Print) | | | t and Number or Rur | | | |
| W. C. L. C. C. | 1 and Health wm 27 other tr | John Paicos/Son 20a. Method of Disposition | 20 | h Place of Disc | osition (Name of | Avenue, | | | d 20707 ty or Town, State |
| altimore, | tment of tant: If the flury or o | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif | Removal from State | Ivy Hil | emetory or other ple 1 Cemeter 2. Name and Addre | cy 2 | | | Maryland |
| 68760, | v requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the burist-transit about by Physician/Medical Examiner | 23e. Part1 Enter the disease, or comshook, or heart feiture. List only Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due | | nter the mode of dying the mode of dying the mode of dying the mode of dying the mode of t | ing, such as cardiac | Road, La | urel, M | Aryland 20707 Approximate Interval Between Onset and Death |
| Box | d for u | Part II. Other algorificant conditions of | possibilities to death but not | resulting in the | underlying cause of | iven in Part I | 23b. Did tob | acco usa contr | ibuta to the cause of death? |
| P.O. | by the stacke | | | | | | 1 □ Ya | 2 2 No 3 | □ Probably 4 □ Unknown |
| Records, | The law requires that the death certale has been signed by the attending page 2 should be detached for use Completed by Physician/N | | | | | | 24a. Was en | | 24b. Were autopsy findings available prior to completion of cause of death? |
| Re | he la e has age 2 | | | | | | 1 □ Yes | 2 XNo | 1 □ Yas 2 No |
| | entificat octor, pr | 25. Was case referred to medical | | | | 26 Plece of Deal | h (Check only one | | |
| | hysician his certification of the certification of | examiner? | Hospitel: 1 Inpatient | 2 ER/Outpatio | ent 3 DOA Ot | har 1 d | ome 5 Resider | | (Specify) |
| Division of | To the Hospital or Attending Physician: The law within 24 hours after death. To the Furneral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp | 27. Menner of Death 12 Natural 5 Pending investigation | | 28b. Time Injury | Wo | ry at ork? ⊇ Yes 2 □ No | 28d. Describe how | w injury occurred | |
| | ball or Attending Pins attending Pins afford death. al Director: Affert lied in by the funeration: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homlcide determined | | At home, farm, soecify) | treet, factory, offica | | 28f. Location (Str. City or Town, | | or Rural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in Medical Cert | | niner: On the best of my niner: On the basis of exar and menner stated. | | | | | | |
| | Within To the Comp | 29b. Signeture and title of certifing | 1. 1.00 | | 29c. Licen | se number | 29 | d. Date signed (| Month, Dey, Year) |
| | 10 | prode pleas | accomin . | | 115 | 0116 | | 0/5/0 | 1000 |
| | Q | 30. Nama and address of person who | of MIN. 8 | (Item 23a) (Type 3/7 C) | herry L | 6716 Lane, L | auje/, | MIS. | 20707 |
| | State Registrar | 31. Date filed (Month, Day, Year) FEB 1 | 2000 \ 32. Registrers 5 | Signature | B \$6 | all | | | |



Piease Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Flizabett 6:20 P.M. 00 Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Health & Rehabilitation KUNIUM M Under If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sax 7. Age (In yrs. last birthday) Days 10 M 28F Months Hours 220-56-9580 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No. 01 MUZ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2⊟ No Specify 3- Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 11cm OSKEI 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21403 Annapolis, Md Guardian Horker. 320 tones 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Hery, cre 1 Burial 2 □ Cremetion 3 □ Removel from State 27-00 Owensville, Maryland lemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address diffacility Funeral Home & Services left Miller P.C. Funeral Home & Services Jeff Miller 1639 North 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a con Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No 26. Place of Daeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b Time of

Examiner Examiner The law requires that the death certificate be executed and the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medicai signed by the atter this certificate has To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifical completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f ahon man be notified at

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al Hygiena.

. Pages 1 and 2 should be filt ment of Haalth and Mental Hyant: If Item 27 is marked oth jury or other traumatic event

permit. Page Department of Important: If any injury or page.

Physician /Medical

Funeral Director

by

Completed

death with the Manyland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Completed by 25. Was case referred to medical examiner? Be 1 Yes 2 No Medical Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifler

29b. Signature end title of/certifier

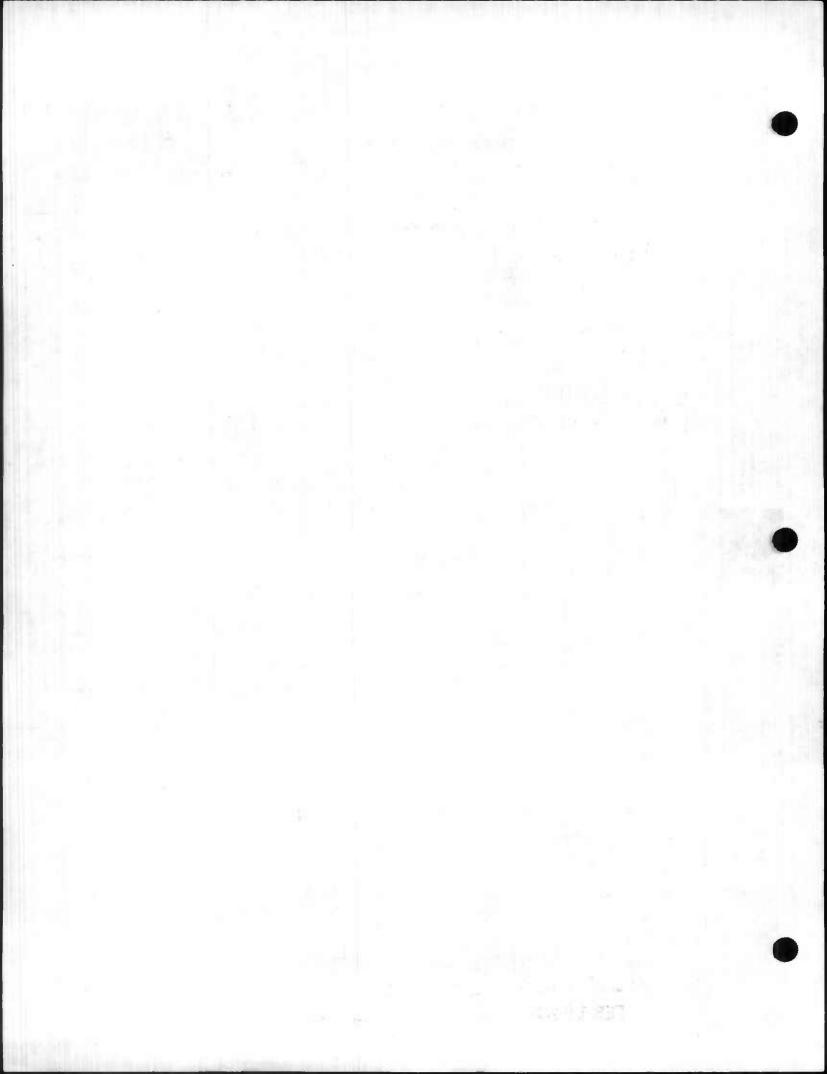
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year)

Drive Cheadepe, MD2/619

Orous 31. Date filed (Month, DAY, Year) FEB 1 0 2000 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06051 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Dev Month Eva Waters Price January 29, 2000 6:15am 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months 1 M 20XF 82 220-12-6244 Feb. 25, 1917 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits n/a Baltimore XXYas 2 No 10a Street and Number 10f. Zip Code 10a. Citizen of What Country? 1110 Clendemin Street 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Black. 3 2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Dietician-School Dept. Chicago, Illinois 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Ira T. Waters Serena Kiah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Waters Brother 1110 Clendemin Street Baltimore, Md. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata † Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park Feb. 3 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Gerber nutter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) Athero Scherotic Cardio vascular Disease Hypelip demi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 20 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 200 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 10 Natural 5 Pending investigation

physician and the burlei-transit The law requires that the death cartificets be executed USB 88 t signed by the e certificate hes b lirector, page 2 s tal or Attanding Physicien: The state death.

It Director: After this certificated in by the funaral director, pa 8 Certification: To filled in by

Physician

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'natural', or

Hyglene. Other than 'n

permit. Pages 1 and 2 ahould be lited in Department of Health and Mental Hygen Importants if her 27 is marked other the any injury or other trainmatic.

Physician

/Medical

Examiner

Physician/Medical Examiner

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Completed

72 hours after

21215-0020

Baitimore, Maryland

Box 68760. P.O. Records, of Vitai Division To the Hospital of within 24 hours at To the Funeral Completaly filled

State Registrar

FEB 1 0 2000 **DHMH 16 Rev 6/95**

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of

6 ☐ Could not be

29c. License number D32158

1 Yes 2 No

TS-Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 3/00

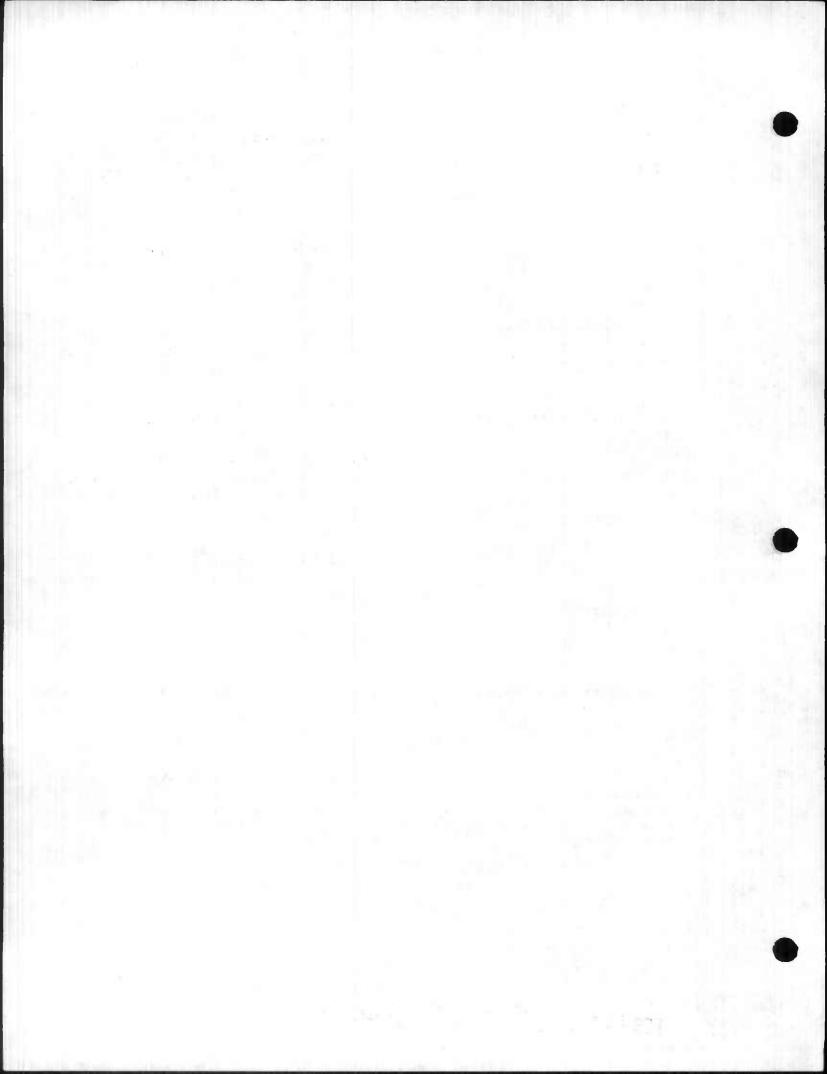
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Name and address of good who completed cause of death (Item 23a) (Type, Print)

Parikly mp 821 N. Eutaw Street, suite 407, Baltimore, MD 2/201 Tyotin 31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

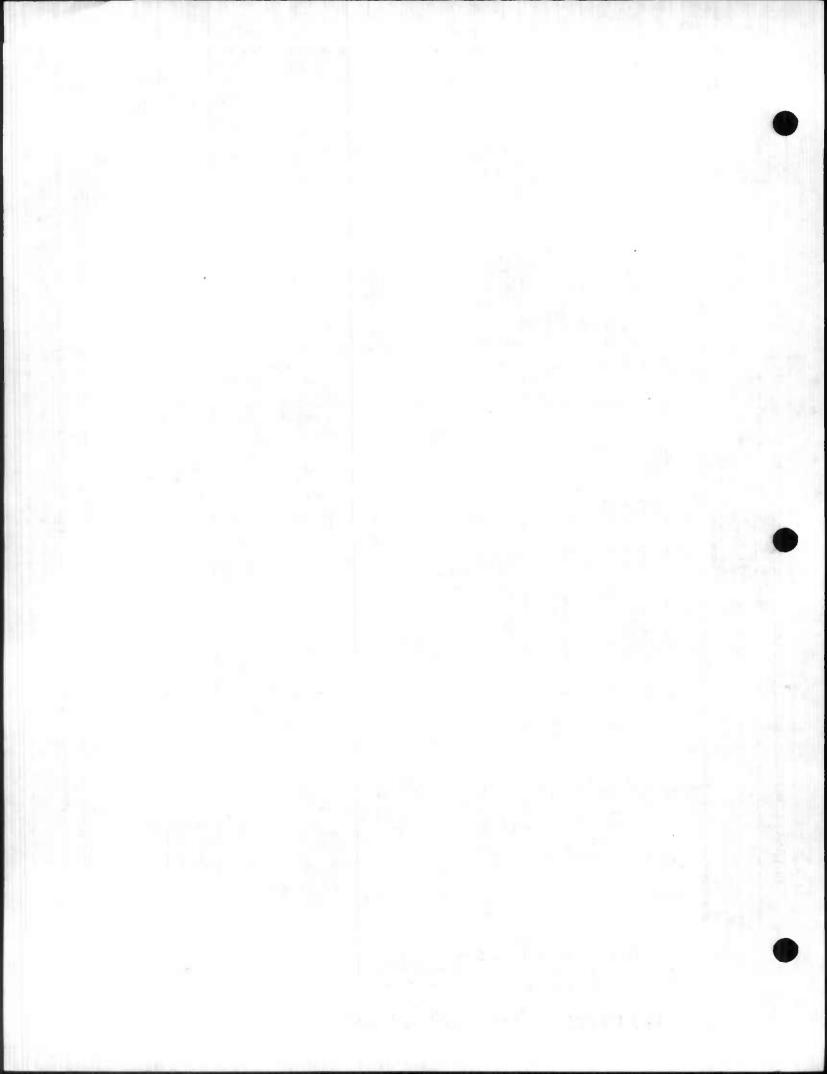


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State of Maryland / De

| epartment of Health and Mental | Hygiene | 00 | 04 | n E | |
|--------------------------------|----------|----|-----|-----|--|
| Certificate of Death | Reg. No. | 00 | 0 4 | U | |

| ysician Jedical aminer | | | | | Ce | rtificate | of e | Death | | | Reg. No. | | 0. |
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| ledical | 1. Decedent's Nar Oricca | me (First, Middle, L H • Pa | ast) almer | | | | | | | 2. Data of D Month | eath Day | Year | 3. Time of Death |
| | | (If not institution, g | | ber) | | | \neg | 4b. City, To | wn, or Lo | FEBRU | ARY 3, | 2000 unty of Death | 1950 PM |
| | | OODSON R | | | | | | BALTI | | | n/ | | |
| eral ctor | 5. Social Security 212–12– | 3247 | Sex 7. | . Age (In yrs. la | est birthday) Yrs. | Months | Days | | Min. | 8. Data of Bi (Month, D April | ay, Year) | Cou | place (Stata or Fora ntry) MC • |
| | Usual Residence 10a. State Md • | 10b. County | n/a | 10c. City | , Town or Lo | ocation | Ba1 | timor | e | | | | 10d. tnside City Lim |
| Director | 10e. Street and No | | | | | 10f. Zip (| Code | | | | 10g. Citizen | of What Cou | |
| | 1008 Wo | odson Roa | - | | | | | | | | USA | | |
| by Funeral | | rried 2 Married 4 Divorced | 12. Was Deced Armed Forc 122 Yes 2 If Yes, Give Year or Date | es? | 100 | Was Decede If Yes, specil 1 ☐ Yes 2] | ly Cub | an, Mexicar | gin? (Spe i, Puerto f | cify Yes or N Rican, atc.) | | Rece · Amari Black, Whita, ecity: B1 | atc. |
| Completed | (Spe | 15. Decedent's E acify only highest grondary (0-12) | Education rade completed) College (1-4 | lor 5+) | (Give | dent's Usual kind of work DO NOT use | done retire | during mos | t of workin | ng | | f Business/Ir | /Pitts., |
| Be | | (First, Middle, Las | 2 | | Nulse | S AIU | | | | (First, Middle atthews | , Maiden Sur | | /PICCS., |
| To | | lame/Relationship HOWard Co | (Type, Print) OX Si | ster | | | | | | | ber, City or To | | o Code) |
| | | sposition Cremation 3 5 Other (Spec | | eta C8 | metery, crea | osition (Name metory or oth Forres | ner ple | | ansFe | Data | 20c. Locati | on - City or T | |
| | | uneral Service Lice | | | 22 | 2. Nama and | Addre | ess of Facilit | Nutt | er Fu | neral H | lomes, | Inc. |
| Medical Examiner | disease or conditi- resulting in death) Sequentially list of if any, leading to icause. Enter Und Cause (Disease of that initiated even resulting in death) | onditions, mmediate lenying r injury ts | a. Hypert | Due to (or | as a consecutation as a consecut | quence of): | ero | otic C | ardio | ovascu | lar Dis | sease | |
| Physician/ | Part II. Other sign | ificant conditions | contributing to deal | th but not resul | lting in the u | nderlying car | use gi | iven in Pert I | | | tobacco use | | to the cause of dea |
| Completed by | | | | | | | | | | perf | s en autopsy ormed? PECTION | a a | fara autopsy finding vailable prior to omplation of causa f death? |
| | | | | | | | | | | 10 | Yes XXN | 0 1 | ☐ Yes 2☐ No |
| To Be | 25. Was case refe examiner? XX Yes 2 | | Hospital: | patient 2 E | D/Outnotice | nt 3 DO/ | Ott | hor | | (Check only | ona) idence 6 🗆 | Other (Cons | 16.43 |
| | 27. Manner of Dea | | 28a. Data of (Month, | | 28b. Tima o Injury | | c. Inju Wo | | 2 | | how injury or | | "97 |
| Certification: | 3 Suicide 4 Homicide | 6 Could not I | 28e. Place of | Injury - At hor , etc. (Specify) | | reet, fectory, | office | | 2 | | (Street and N iwn, Stata) | umber or Rui | ral Routa Number, |
| | 29a. Certifier (Check only one) | | hysician: To the be miner: On the basi and manne | is of examination | | | | | | | | | |
| | | | | | | 29c. | Licens | se number | | | 29d. Data si | gned (Month, | Day Year) |
| Medical C | 29b. Signature an | d title of certifier | 2 Che | tom | | | 00 | ME | | | FEBRUA | RY 4, | - |
| edical | 30. Name and add | ress of person who | L Chu completed cause | tem of death (Normal 111 Per | | | | | e, Ma | aryland | | | - |

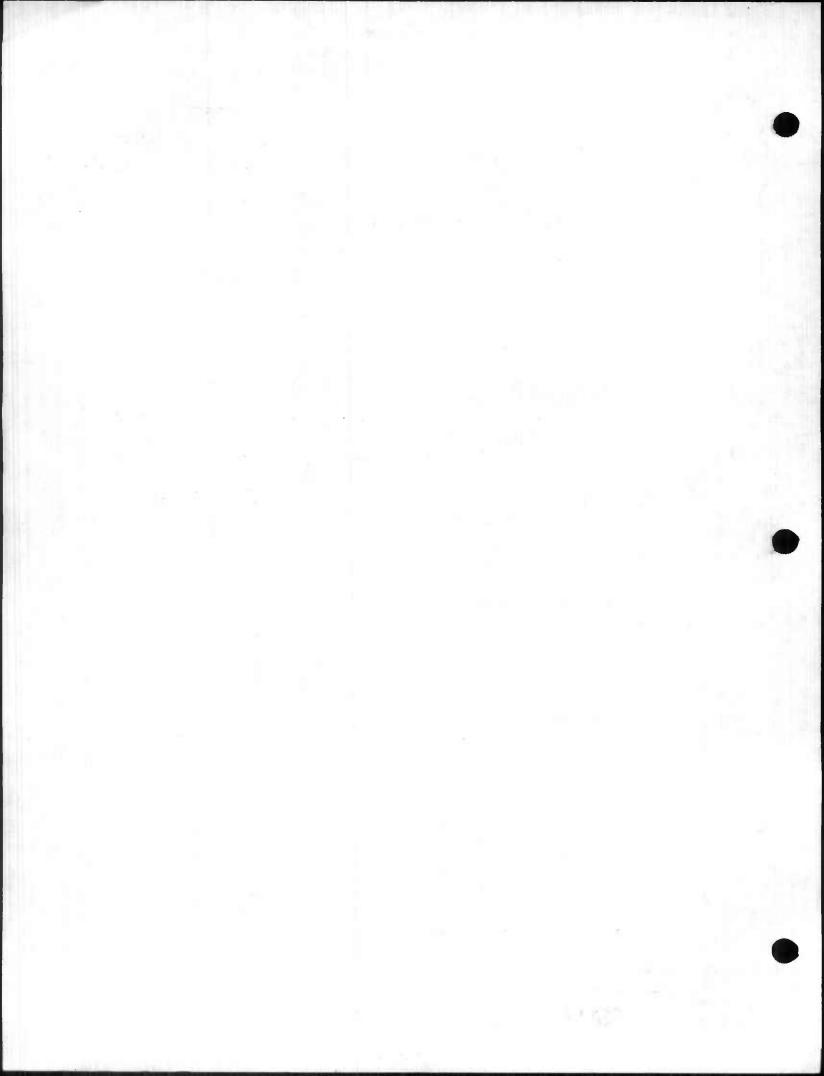


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State of Maryland / Department of Health and Mental Hygiene

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| inian | 1. Decedent's Nama (First, Middle, L | ast) | | | | Death | T | 2. Deta of Dear | eg. No. | | 3. Time of | |
|-----------------------------|---|--|---|--|--|--|--------------------------|--|--|---|--|-----------|
| sician | Rosamond Rosend | • | | | | | , | Month | Day | Year | 8:40P | M |
| edical | 4a Facility Name (If not institution, g | | | | | b. City. Tow | | ebruar | 4c. County | | 0.401 | |
| miner | | | | | | Pikes | | | | imore | | |
| | Milford Manor 5. Social Security Number 6. | | ome o (In yrs. last birthd | av) If Und | er 1 Year | If Under 2 | | B. Date of Birth | | 9. Birthi | olece (State o | r Foreior |
| or | 215-05-2731 Usual Residence of Decedent | 1□M 2QF | 84 Yrs | Months | Deys | Hours | | (Month, Day July 26 | | Virg | inia | |
| | 10a. State 10b. County | .1 | 10c. City, Town or | r Location | | | | | Total Control | 1 | l0d. Inside Ci | ty Limits |
| Director | MD. | JA | Baltimor | ce Cit | V | | | | | | 1 🖾 Yes | 2 🗆 No |
| Directo | 10e. Street and Number | | | 1 | ip Code | | | 1 | 0g. Citizen of | Whet Cou | ntry? | |
| | 2500 West Be | lvedere Ave | . #214 | 2 | 1215 | | | | 1 | USA | | |
| Funeral | 11, Marital Status | 12. Was Decedent I Armed Forces? | Evar in U,S. 1 | 3. Was Dec | edent of H | lispanic Origi | in? (Spec | ify Yas or No- ican, atc.) | | | can Indien, | |
| by | 1 Nevar Married 2 Married 3 Widowed 4 Divorced | | | | 28 No | Specify: | rueito n | icari, atc./ | Specif | ck, White, y: Whi | | |
| ted | 15. Decedent's I | Educetion | 16a. De | cedent's Us | ual Occup | ation | of unothin | | 16b. Kind of B | usiness/In | dustry | |
| 음 | (Specify only highest g Elementery/Secondary (0-12) | College (1-4or 5 | +) (G | e. DO NOT | usa retire | during most (| or workin | | | | | |
| Completed | 12 | 00000 (101.0 | | omemak | er | | | | Own H | ome | | |
| Be | 17. Father's Neme (First, Middle, Las | st) | | | | 18. Mother | s Name | (First, Middle, I | Meiden Sumar | ne) | | |
| TOE | Joseph Britton 1 | Peery | | | | Eliz | abet | h Gibs | son | | | |
| | 19a. Informent's Neme/Relationship Mr. Todd Rosenda. | | | - | | | | Route Number TOWSON , | | | Code) | |
| | 20a. Method of Disposition | | 20b. Place of Di | sposition (N | eme of | na) | - | Date | 20c. Location | - City or To | own, State | |
| | 1 ☐ Burlel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Othar (Spec | | Hillton | | | , | 12- | 12-00 | Towso | n, MI |). | |
| | 21. Signeture of Funeral Sarvice Lice | - 8 | HILLO | - | | ss of Facility | 1 | | | | | |
| | DX +1 | P. / | | Ruc | k To | wson F | uner | al Home | e Inc. | | | |
| | 23a. Part1. Enter the disease, or on shock, or heart failular. List on | Loughy | | 105 | O Yo | rk Rd. | Tow | son, MI | 2120 | 14 | Approximet | |
| cian/Medical Examiner | Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events | b | Due to (or as a con | sequence of |): | | | | | | | |
| 3 | resulting In deeth) Last | d | 208 to (or es e con | sequence of | , | 15 | | | | | | |
| sicia | Pert II. Other significant conditions | contributing to death bu | it not resulting in th | e underlying | ceuse giv | en in Part I. | - | 23b. Dfd to | obacco use co | ontribute t | o the cause | of death |
| y Physician | | | | | | | | 1 D Y | es 2 No | 3 Pro | bably 4 🗍 | Unknow |
| d b | | | | | | | | 040 11/000 | in autopsy | 8/ | are autopsy statements | 0 |
| pietec | | | | | - | | | perfor | med? | of | death? | 1 |
| ompleted | 3 | | | | | | | perfor | / | of | death? ☐ Yes 2 | No |
| 3e Completed | 25. Was cese rafarred to medicel | | | | | 26. Plece | of Death | perfor | es 2 0 No | of | death? | No |
| 89 | 25. Was cese ratarred to medicel examiner? | Hospitel: 1 ☐ Inpatie | nt 2□ER/Outpa | utient 3 [| DOA Oth | | / | perfor | es 2 0 No | 1 | déath? □ Yes 2Œ | 110 |
| To Be | examiner? 1 Yas 2 No 27. Manner of Death | 1 L Inpatie | | e of | JUA | ier: 4 DNUr | sing Hor | perfor | es 2 0 No | of 1 her (Speci | déath? □ Yes 2Œ | 110 |
| To Be | examiner? 1 Yas 2 No | 28e. Date of Injur (Month, Day | y Year) 28b. Tim fnju | e of ry M | 28c. Injui Woi 1 | ier: 4 DNUr | sing Hom | perfor 1 Y (Check only or | es 2 0 0 one) ence 6 Otto | ner (Special | death? ☐ Yes 2 [®] | |
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| Certification: To Be | examiner? Yas 2 No | 28e. Date of Injur (Month, Day | y 28b. Tim fnju iry - At home, ferm. (Specify) | e of ry M , street, tacto | 28c. Inju | y et k? Yes 2 N | sing Hom 2 lo 2 | (Check only or (Check only or 5 | es 2 0 no ence 6 Otto ow injury occu treet and Num n, Stete) euse(s) and m | her (Special red | death? ☐ Yes 2 ☐ fy) al Route Num | nber, |
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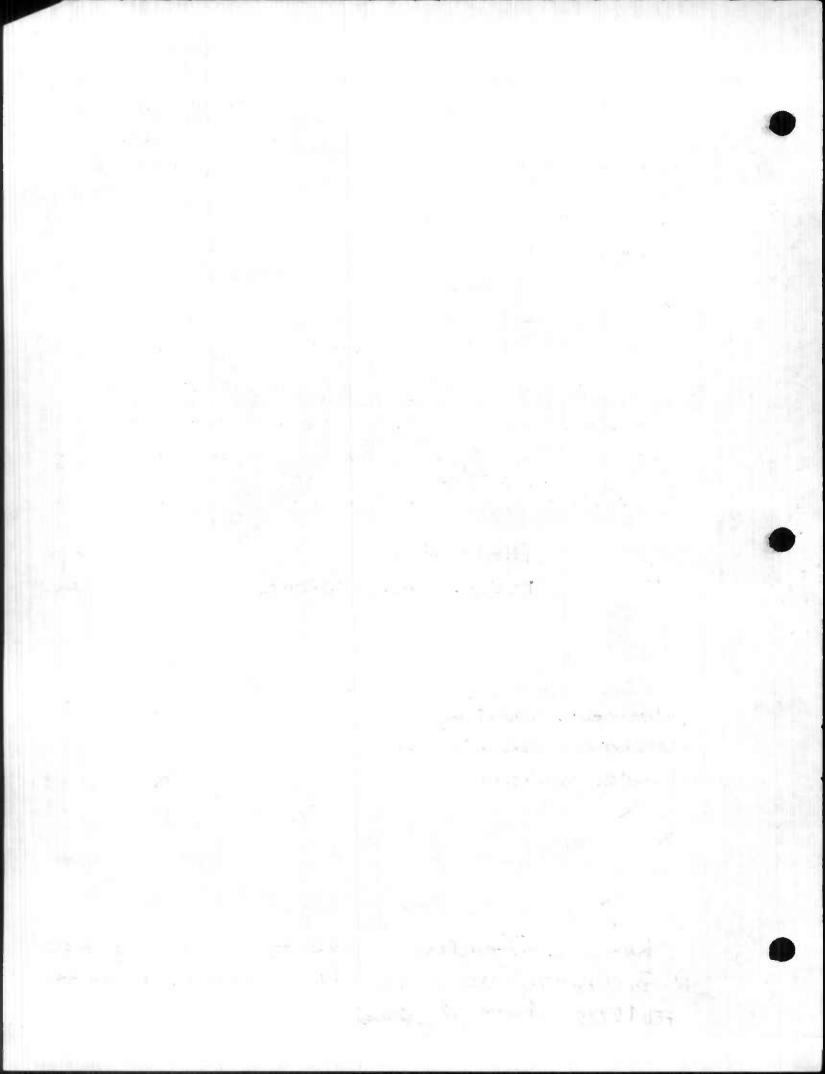
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey Month Year **Physician** Joseph Thomas Ruskey, Sr. February 9, 2000 1:00 a.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Village Care Center Parkville Baltimore Co. 8. Dete of Birth (Month, Day, Year) Feb. 13, 19 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs 91 Feb. 1908 **Director** 216-01-5102 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Co. Directo Parkville Maryland 10f. Zip Code 10e. Street and Number 10g. Cifizen of What Country? 21234 8832 Walther Boulevard United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician General Motors 7th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be To Simon Stacharowski Mary Geleski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) If Item 27 or other tr Baltimore, Maryland Mrs. Patricia C. Sobotka/Daughter 2204 Louise Avenue altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 🛱 Other (Specify) Entantment Glen Haven Mem. Gardens 12/12/2000 Glen Burnie, MD 22. Name and Address of Fecility Michael E. Canapp 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician PNEUMONIA /Medical Immediate Cause (Final diseese or condition resulting in death) **Examiner** Examiner TCUTE_VIRAL SYNDROME The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Box 68760. Physician/Medical Due to (or es a consequence of): been signed by the attendin should be detached for use Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? o 2K No 3 Probably 4 Unknown 0 Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? brovasalar diseose 24a. Wes an autopsy performed? melliti diobetes 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No 4 hours after death Funeral Director: / 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide ò Hospitat within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 2 2564 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud/Baltmerc, MD 21234 raullings MD 8800 Weeth 31. Date filed (Month, Dey, Year) 32. Registrar's Signature FEB 10 Registrar 2000

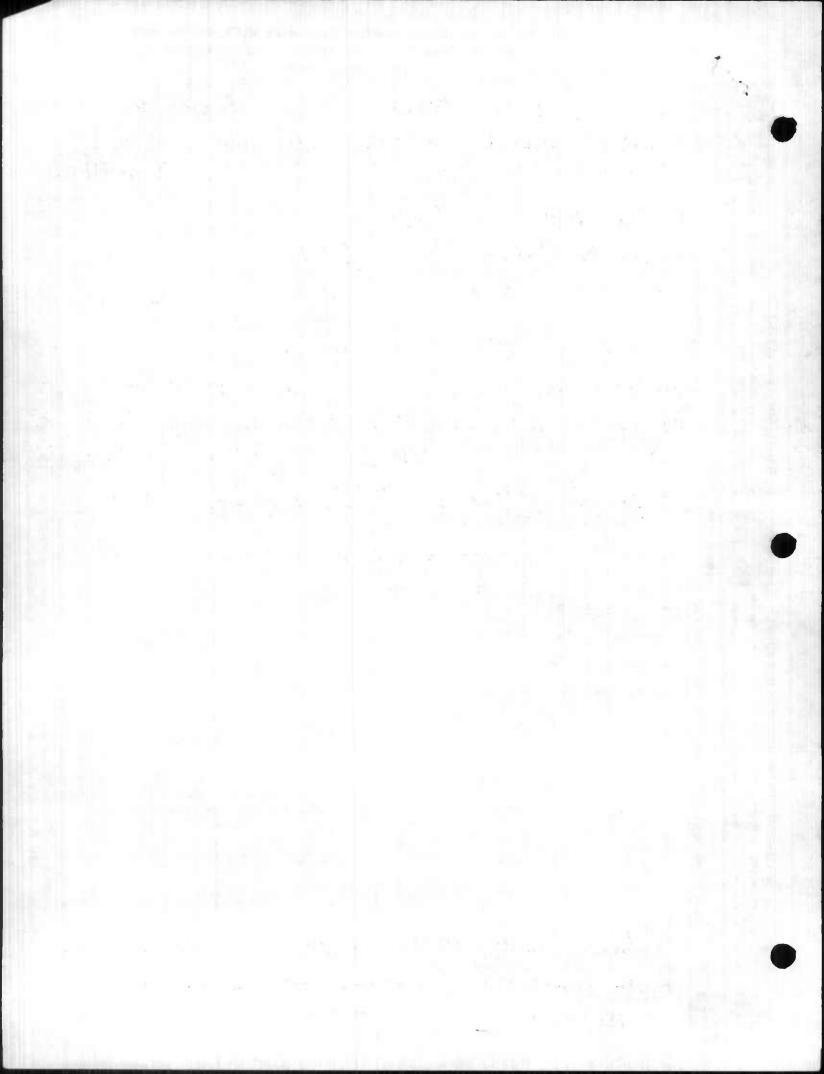
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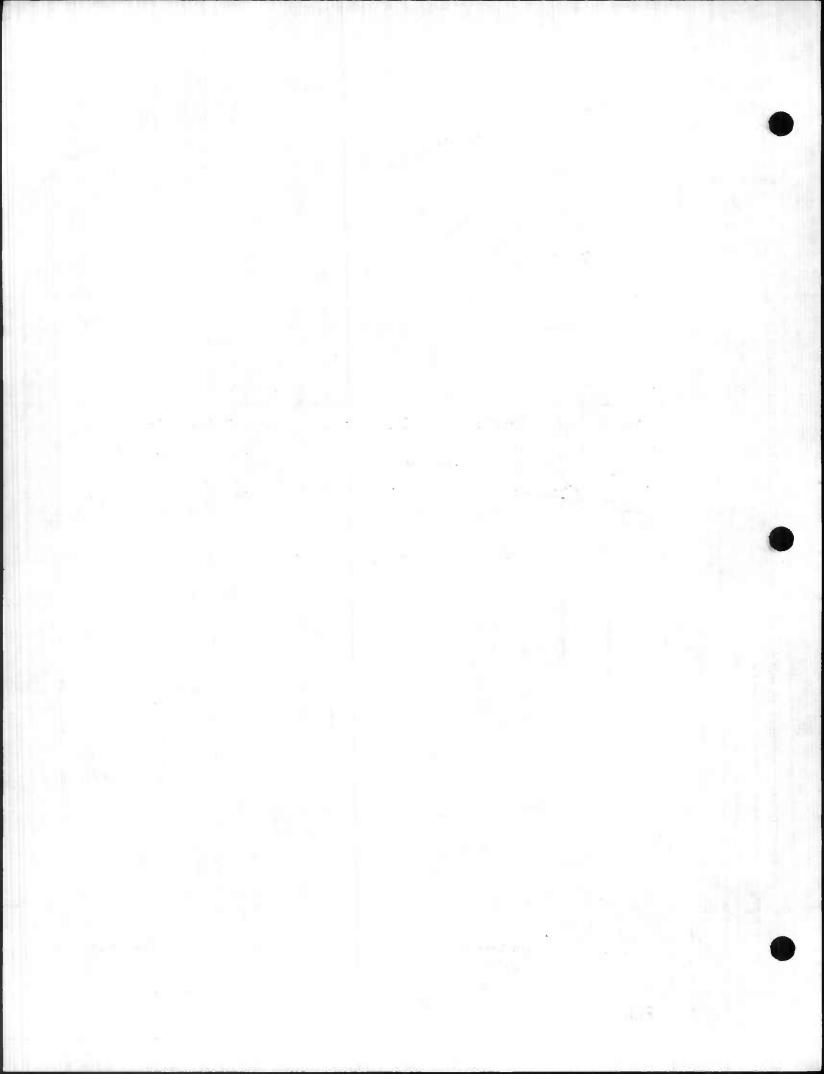
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Day Year FEBRUARY 9 2000 **Physician** 9:13am MARY RITKO /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Kent & Queen Anne's Hospital Chestertown Kent If Under 24 Hrs. Hours Min. 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Devs 86 Yrs. 220 62 2990 Director PENNSYLVANIA Usual Residence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner, must be notified at 1 Yes ZENo MD BALTIMORE ROSEDALE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8037 OLD PHILADELPHIA ROAD 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondery (0-12) OWN HOME 0 HOMEMAKER permit. Pages 1 and 2 should be illed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event. I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 0 JOSEPH ORLOSKY ANNA BUHOVESKY 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11736 BROWNTOWN ROAD KENNEDYVILLE, MD 21645
Disposition (Name of Date 20c. Location - City or Town, State CAROL WEINREICH / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 1 Burial 2 Cremation 3 Removal from State 2/12/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Special HOLY REDEEMER 21. Signature of Furreral Service Ucensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE. MD 21237 23a. Part 1. Emer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical BUTT MYCEMMIGE INFMETRY 10 mm Examiner Due to (or as a consequence of): physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Records, P 24b. Were autopsy findings available prior to 24a. Was an autopsy parformed? Completed peen completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | SER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After ti Certification: 28b. Time of 28c. Injury at Work? After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stafed. 29a. Certifier Medical (Check only one) within 2 \$ 29c. License number 29b. Signeture and fittle of certifier 29d. Date signed (Month, Day, Year) 00013824 2-9-00 30. Name and oddress of parson who completed cause of death (Item 23a) (Type, Print) John C. Seymour MD 122 Speer Rd. Chestertown, MD. 21620 2. Registrer's Signature 31. Date filed (Month, Dey, Year) State FEB 1 0 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 07,2000 FEBRUARY NANNIE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** GENESIS ELDER CARE MANOR ALTIMORECIT If Under 1 Year Under 24 Hrs 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 M 200 F 220-24-8965 Director -OBINSON, NANNIE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA 1 Pes 2 □ No BALTimore Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23s or 21223 USA Funeral Lou Street 106 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bieck, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1□ Yes 2 No Specify: Maryland 21215-0020 3 ₩idowed 4 Divorced Year or Detes: American Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 40Mes 12 NA 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be Health and Mental 2 Mar Tha 105€ 19a. Informent's Neme/Relationship (Type, Print) 50 N 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) or other traus 20b. Place of Disposition (Name of cametery, cremetory or other place) BANIMON, MD 21223 Earl altimore, 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) flowing 12,200 Randoll o Town, MID Park 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility StreeT 638 N. Gilmon 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. 21217 Physician /Medical Immediete Cause (Final months diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) 88 ate has been signed by the attendin page 2 should be detached for use Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 1 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 25 No this certificate Division of Vital or Attanding Physician: director, 25. Wes case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funerai 28c. Injury at Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyeiclen: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end menner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and manner stated. 29e. Certifier (Check only one) completaly \$ 29c. License number 29d. Date signed (Month, Day, Year) -40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 Wilkens

State Registrar

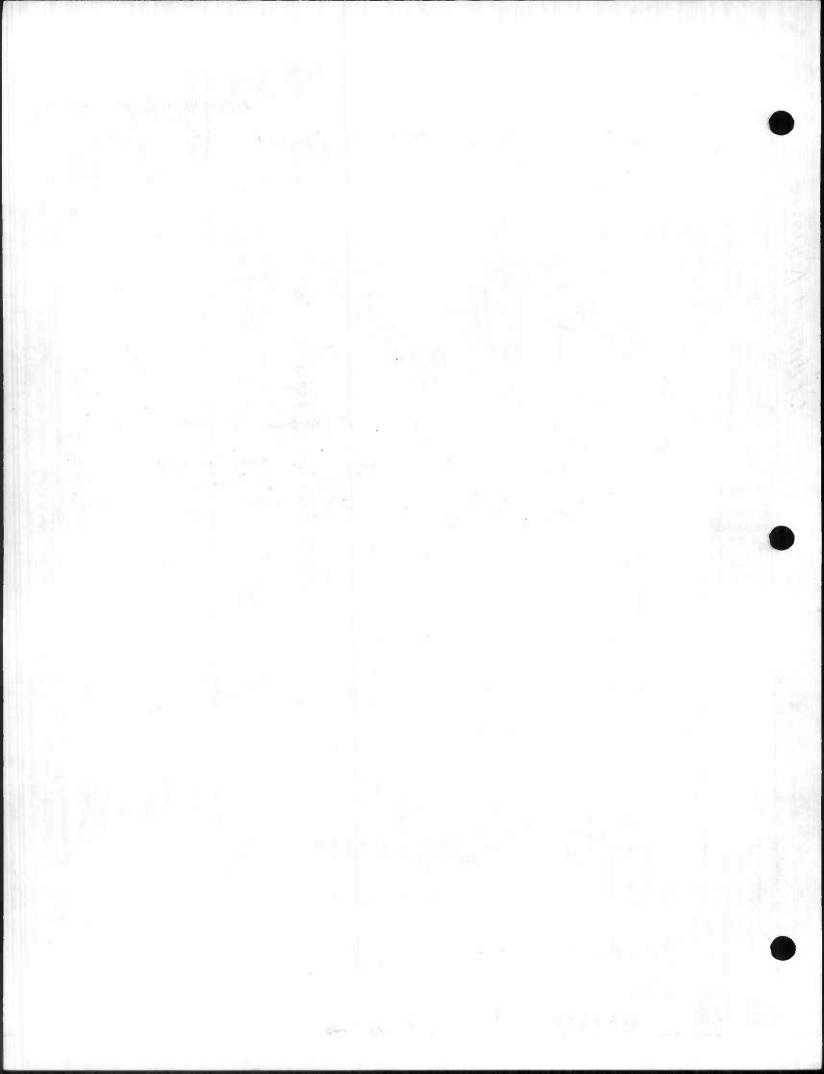
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32. Registrer's Signeture

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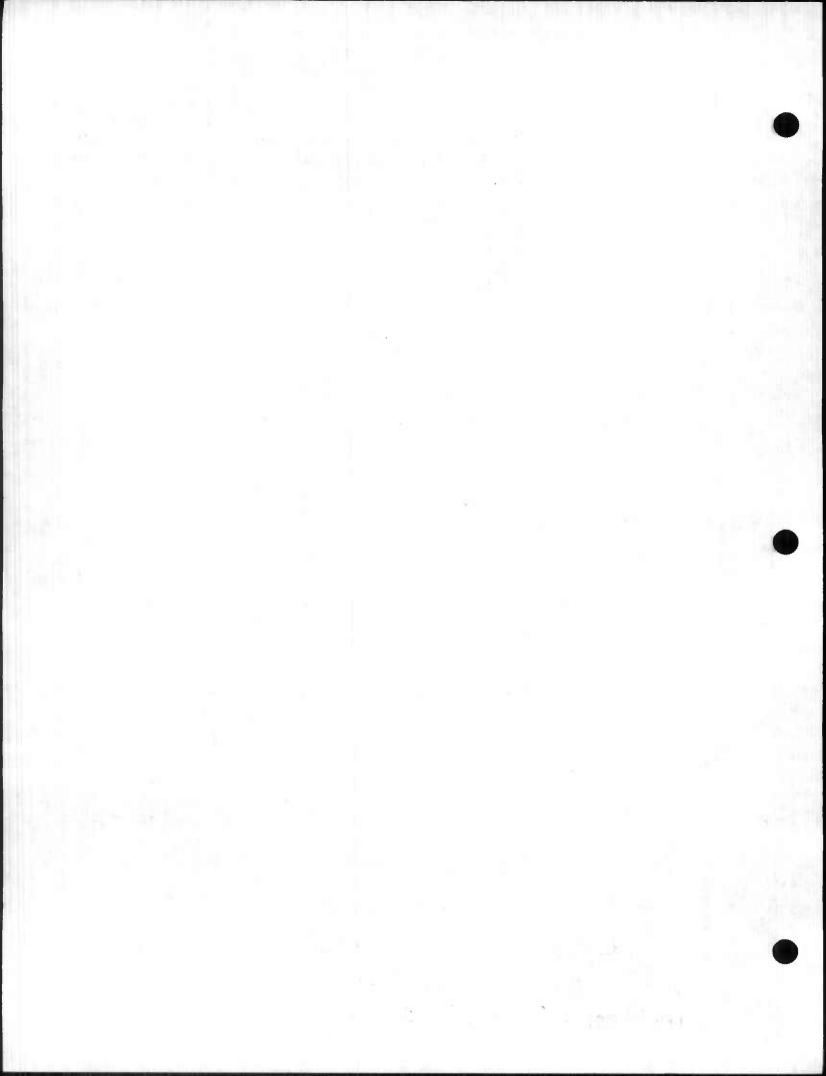


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State of Maryland / Department of Health and Mental Hygiene

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| /Medical | JAY | | | ROSEN | | | | FEBRUARY 8, 2000 | | 7:09 AM |
| Examiner | 4e Facility Name (If not institution, give street and number) 7234 PARK HEIGHTS AVENUE #B 4b. City, Town, or Location BALTIMORE | | | | | | ORE | E N/A | | |
| uneral | 5. Social Security Number 214–26–9619 | 6. Sex 7. A | ge (In yrs. lest birth | dey) If Under Months | 1 Yeer Deys | If Under 24 Hours N | in. 8. Dete of B | irth Pay, Yeer) | 9. Birth | piace (Stete or Forentry) |
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| ypiene. v. tha Medical Examiner must be notified at Completed by Funeral Director | MD N/A | | BALTIM | ORE 10f. Zip | 0-4- | | | 100 China of h | Affred Court | 1 ∑ Yes 2 □ |
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| sician cuicar miner | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Ceuse (Finel disease or condition resulting in death) | r complications thet cause only one ceuse on each | ed fhe death. Do no line. | ot enter the mod | de of dyin | g, such as card | diec or respiretory | arrest, | | Approximete Intervel Betwee Onset end Deel |
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| Funeral Director: After this certificate has been signed by the tely filled in by the funeral director, page 2 should be detached tely filled in by the funeral director. To Be Completed by Phys | examiner? 1 Yes 2 Ne 27. Menner of Deeth 1 Naturel 5 Pendir 2 Accident 6 Could 4 Homicide detem 29e. Certifier 1 Certifyir (Check only 2 Medical | Hospital: 1 □ Inpat 28e. Dete of Inj (Month, D) 28e. Place of Ir building, e 28e. Place of Ir building, e ang Physician: To the besis and manner s | ury Year) 28b. Till Injury - At home, femotic. (Specify) t of my knowledge, of examination and | patient 3 D Or me of lury M M m, street, factor deeth occurred for investigetion | OA Oth. 28c. Injun Worl 1 y, office et the tim ,, In my of | er: 4 Nursin y at k? Yes 2 No | 24a. We per 1 Deeth (Check only g Home 5 2 Re 28d. Describe 28d. Location City or 7 ace, end due to the | yes 2 No yes an autopsy formed? Yes 2 No yone) sidence 6 Ott e how injury occur (Street end Numiown, Stete) e ceuse(s) end m | 3 Production Productio | Jobably 4 Unk Jere autopsy findic valiable prior to propletion of cause of death? Yes 2 No ify) al Route Number, stated. to the ceuse(s) |
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| 44 nours are feath. Funeral Director. After this certificate has been signed by the feath filled in by the funeral director, page 2 should be detached lical Certification: To Be Completed by Phys | examiner? 1 Yes 2 Ne 27. Menner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signeture at the of certifier | Hospital: 1 □ Inpat 28e. Dete of Inj (Month, D) getion not be 28e. Place of Inbullding, e ang Physician: To the basis and manner s | ury - At home, fen dic. (Specify) It of my knowledge, of examinetion and | patient 3 Dome of Jury M m, street, factor deeth occurred for investigation | OA Oth. 28c. Injun Worl 1 y, office et the tim ,, In my of | er: 4 Nursin y st k? Yes 2 No ne, date end pl pinion, deeth o e number | 24a. We pei 1 Deeth (Check only g Home 5 Re 28d. Describe 28d. Location City or 7 ace, end due to the courred et the time | sen autopsy formed? Yes 2 No. Yone) sidence 6 Ottle how injury occur (Street end Num. own, Stete) e ceuse(s) end me, dete end place, 2/8/01 | 3 Production Productio | Jobably 4 Unk Jere autopsy findic valiable prior to propletion of cause of death? Yes 2 No ify) al Route Number, stated. to the ceuse(s) |
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Veronica T. Skiba 5, 2000 February 5:55 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Holy Cross Nursing & Rehab Center Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2XF 92 Yrs. March 17, 1907 Pennsylvania Director 204-12-8309 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or froms 23a or 28a-f ahow 1X Yes 2□No Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6213 Roblynn Road 20707 USA d 2 should be filed within 72 hours after death in and Mantel Hygiena. 7 Is marked other than "natural", or frame 23. fraumate event, the Modes Execute man Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White PV 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cottege (1-4or 5+) Etementery/Secondary (0-12) Clerk Retail 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph Brozyna Mary Urban 19b. Malting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Retationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if Itam 27 is m any Injury or other traum once. Caroline Holt/Daughter 6213 Roblynn Road, Laurel, Maryland 20707 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 K Removel from State St. Kunegunda's R.C. Cem. 2/10/00 McAdoo, PA 4 □ Donation 5 □ Other (Specify) Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, Maryland 20707
Polications the Caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate 21. Signature of Funeral Service Libenses **Physician** /Medical Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that be listed aways.) Due to (or as a consequenca of): Box 68760. Physician/Medical that Initiated events resulting in death) Last Due to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS þ 24b. Were autopsy findings available prior to been si Completed 24a. Was an autopsy completion of cause of death? certificata has t director, pege 2 s 1 Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Dey Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Watural 5 Pending thin 24 hours after deeth. the Funeral Director: Af mpletaly filled in by the fu deeth. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the I within 2 To the I complet 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2/6/2000 DZ4991

8317 CHERRY LANE LAURET MI)

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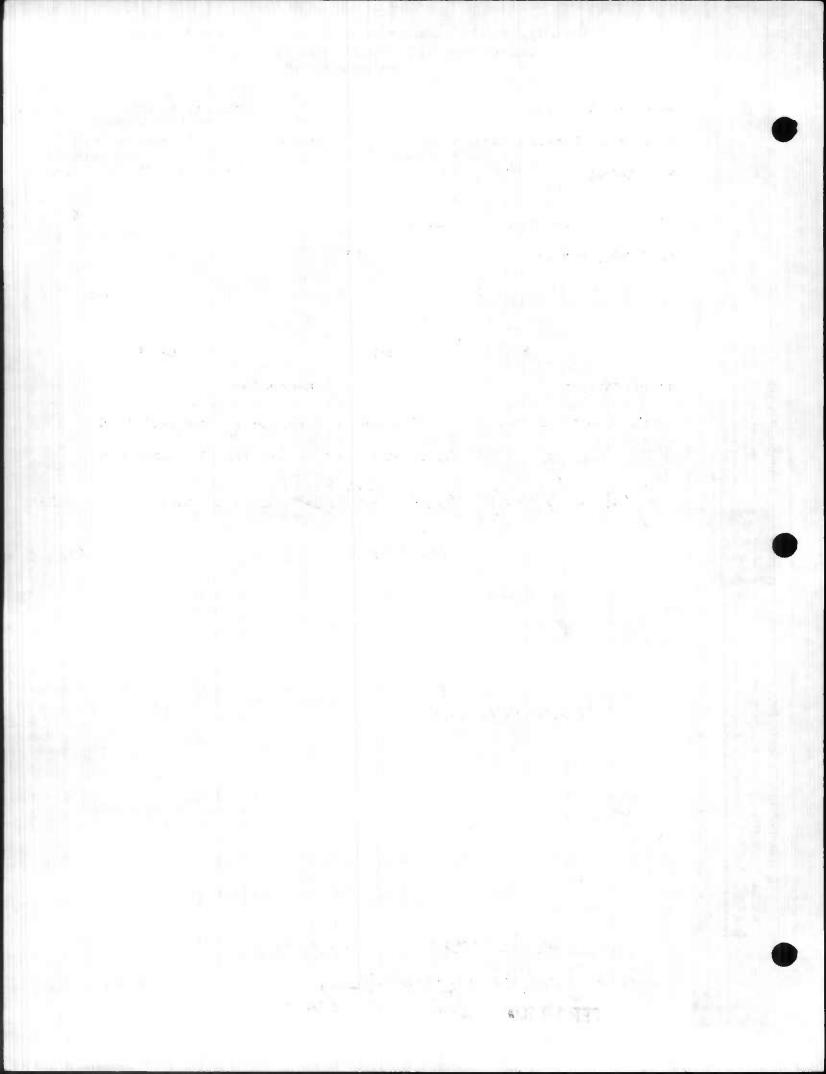
State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

A. CASAS MD

FEB 10

LUIS A. CI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

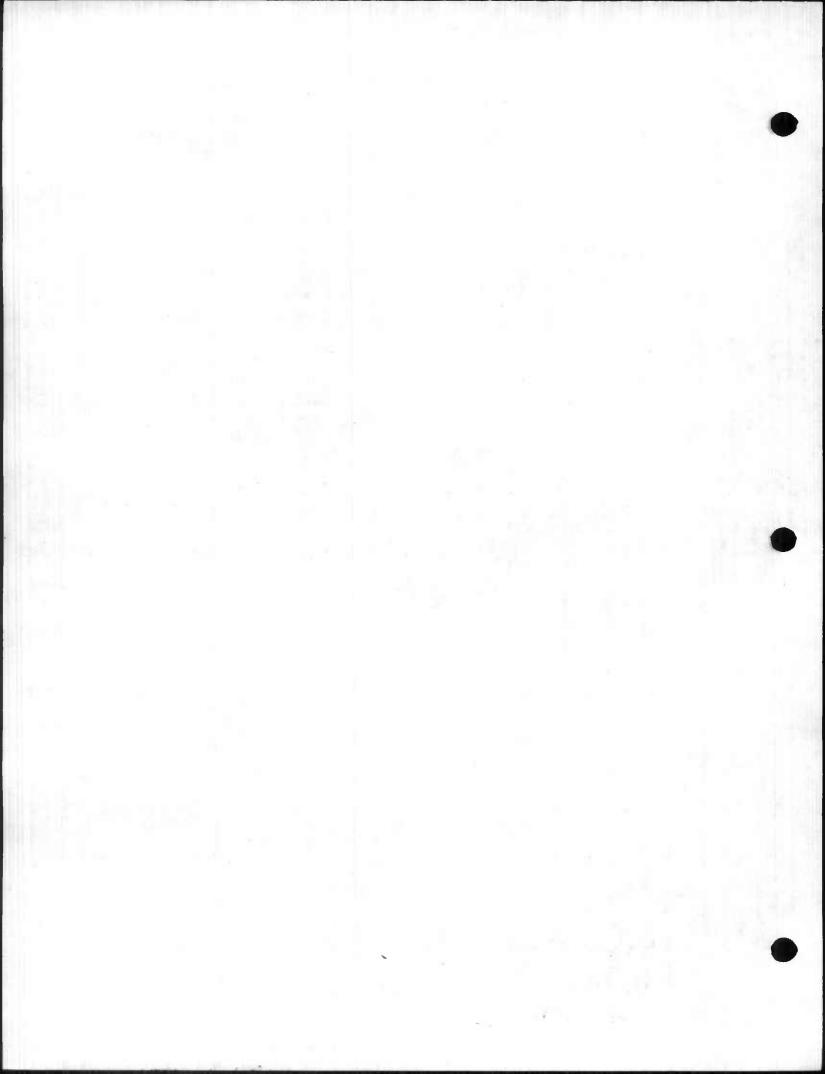
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** 7, FEB. 2000 CHRISTINA F. STEMPOR 9:30PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON DULANEY-TOWSON HEALTH CARE CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 93 Director 212-09-0408 PENNSYLVANIA Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits show na 23a or 28a-f shor 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2634 MASSETH AVE. 21219 USA Funeral Herne. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 21215-0020 natural', or 1 ☐ Yes 2 No Specify: py Specify: 3 Midowed 4 Divorced WHITE Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bualness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Department of Health and Meniel Hygiene. Important: If Ism 27 is marked other than any injury or other traumatic avent, the Monee. HOMEMAKER HOME Baitimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be MYRA ELLA SOLES JOHN H. BLYMYER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 21221 CAROLYN RZECZKOWSKI 44 YEW RD. BALTIMORE, MD. 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State GREEN MOUNT CEME. 2/8/2000 BALTIMORE, 4 ☐ Donetton 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO. 21222 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** bstructive Pulmonary di Seus /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ementia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of). physician s the buria Box 68760, Physician/Medical Due to (or es a consequence of): 98 050 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Meturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation deeth 2 Accident 24 hours after deet Funeral Director: 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide filled in Hospital 29e. Certifier edical 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end manner steted. (Check only one) within 2 To the 29b. Signeture and/fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sician 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Baltimore MD2/21X 0 LHOU Park 300) Worthsom 32. Registrer's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Ray 6/95

Registrar

FEB 1 0 2000

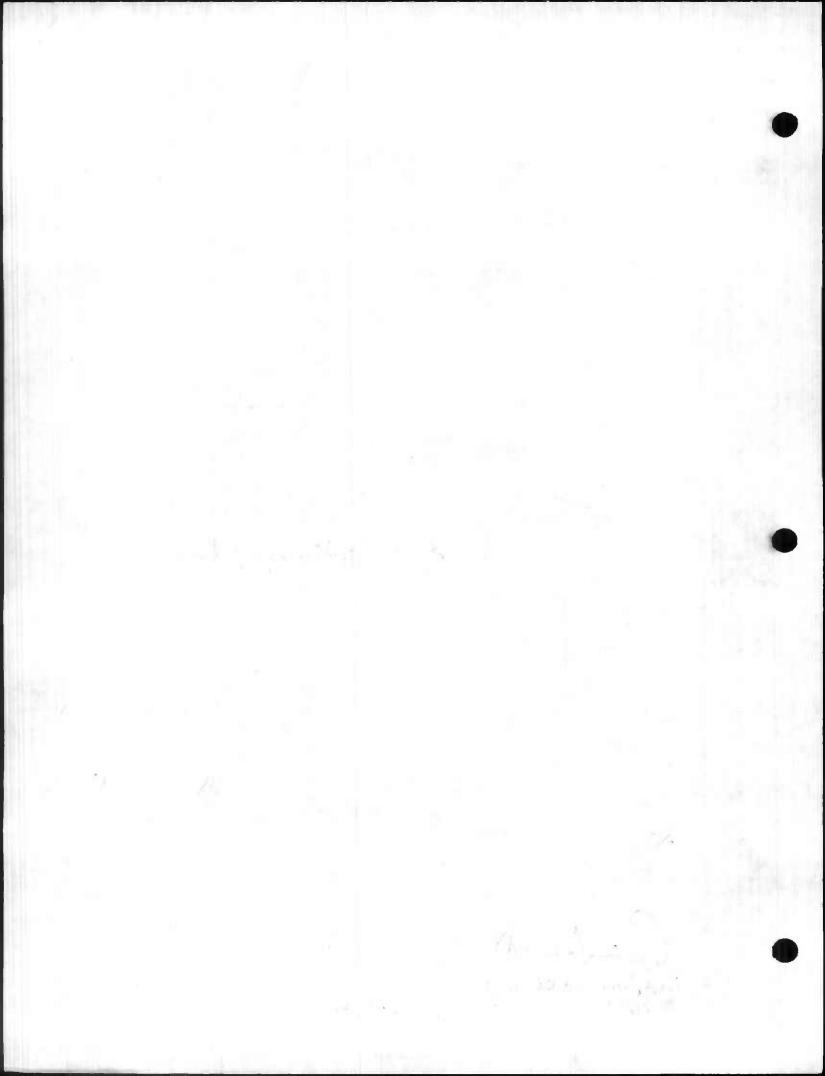
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| | CLIFTON SENTZ JR. | | erer 6 th | | State of I | Maryla | | partme ertifica | | lealth and I Death | | jiene () | 0 04 | 061 |
|--|--|---|---|--|---|---------------------|---------------------------------------|--|--|--|-----------------------------------|---|------------------|---|
| | Physiciar /Medica | 1 [. | CLIFTO | | NTZ JR. | | | | | | 2. Date of Dea Month FEBRUA | Day RY 6,20 | Year 00 2 | Time of Death |
| | Examiner Funeral Director | | | | M LANE | | :. last birthda Yrs. | (y) If Und | er 1 Year | ROSEDAL If Under 24 Hrs. Hours Min. | Đ | | IMORE | (State or Foreign |
| | vith the Maryland or 28s-f show be notified at | | Usual Residence of 10a. State | Decedent 10b. County BALTIMOR | E | | ity, Town or OSEDAI | | | | | | 10d. I | nside City Limits |
| .0020 hours after death with the Maryland ural, or items 23s or 28s-f show Examiner must be notified at id by Funeral Director | | 11. Marital Status | VINCENT F | 12. Wes Decede Armed Force | \$? | U,S. 1: | | | 237 lispanic Origin? (S an, Mexican, Puert | | USA 14. Rec | What Country? ca - American Irck, White, etc. | ndien, | |
| 15-0020 | 21215- d within 72 giene. or then ner t to the lost | 2 | 3 🗆 Widowed | ied 2 Married 4 Divorced 15. Decedent's Edition only highest green | 1 ☐ Yes 2 [If Yes, Give Yeer or Dete lucation de completed) | | (Gi | 1 ☐ Yes cedent's Us ve kind of w | uel Occup | during most of wor | king | Specify 16b. Kind of B | y: WHITE | |
| | | | | (First, Middle, Last) | College (1-4d) | or 5+) | | MPUTE | | OGRAMMER | ne (First, Middle, | | L SECUR | ITY |
| Maryland d 2 should be flie tith and Mental Hy tit amrked othe traumatic event | | | ON E. SEN eme/Reletionship (7 SENTZ / W | | | | | | EVELYN and Number or Ru T FARM RO | | r, City or Town, | , State, Zip Coo | | |
| Baltimore, | ultimore, nit. Pages 1 a artment of Hea ortant: If Nem. Injury or othe | | 4 Donetion | position Cremation 3 5 Other (Specify perel Service Licen | ') | te | Plece of Dis cemetery, co METRO | position (Na remetory or CREMA | arne of other plea TORY | ce) | Dete | 20c. Location | RE, MD | Stete |
| Ba | permit. Departm Importar any Inju | | 1 (- | me diseese, or comport feilure. List only | | sed the dee | | CVAC 121 | H/RO | SEDALÉ FU ESACO AVI | E BALTO | MD 21 | 237 | proximete rvel Between |
| | Physician /Medical Examiner | | Immediete Ceuse diseese or condition resulting In death) | (Finel | a | 711 | ateo or as e cons | C | bro | iong | | | One | set and Death |
| Box 68760, | deeth cartificate be assected estending physician and of or use as the bufal-transit sician/Medical Examiner | | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) | 5 | b | | or as e cons | | | | | | | |
| P.0. | | | Pert II. Other signif | licant conditions co | ontributing to death | but not res | sulting in the | underlying | cause giv | en in Part I. | | obacco use co res 2 No | ontribute to the | cause of death? |
| of Vital Records, | aw requisits been 2 shoul | | | 4 | | | | | | | 24a. Wes a perfor | med? | aveilab | utopsy findings le prior to tion of cause h? |
| f Vital F | ysician: s certific director | | 25. Was case referexeminer? | D - 77 - 15 | Hospitel: 1 ☐ Inpa | ntient 2 |] ER/Outpati | ient 30 C | Oth Oth | or | eth (Check only or lome 5 1 Resid | 10) | ner (Specify) | s 2 No |
| ision thending death. ctor: Attain y the fune | | 27. Menner of Deat 1 Neturel 2 Accident 3 Suicide 4 Homicide | h 5 Pending investigation 6 Could not be determined | 28e. Plece of | Dey Year) | 28b. Time Injury | м | | yat k? Yes 2 □ No | 28d. Describe h 28f. Location (S City or Tow | treet and Numt | | ute Number, | |
| ۵ | he Hospital or A in 24 hours after the Funeral Dire- pletsly filled in b edical Certif | - | 29e. Certifier (Check on one) | 1☐ Certifying Phy 2☑ Medicat Exam | reician: To the be | st of my kno | owledge, de | | | | , and due to the c | ause(s) end me | | |
| | To the Ho within 24 To the Fu Complete) | | 29b. Signature and | title of certifier | an | | | 2 | 9c. Licens | e number | | | od (Month, Day, | |
| 4 | | 1 | 30. Neme and addr | ess of person who c | completed cause o | f death (Ite | m 23a) (Typ | | Penn | Street, | Baltimor | e, Mary | land 21 | 1201 |

State Registrar



Registrar

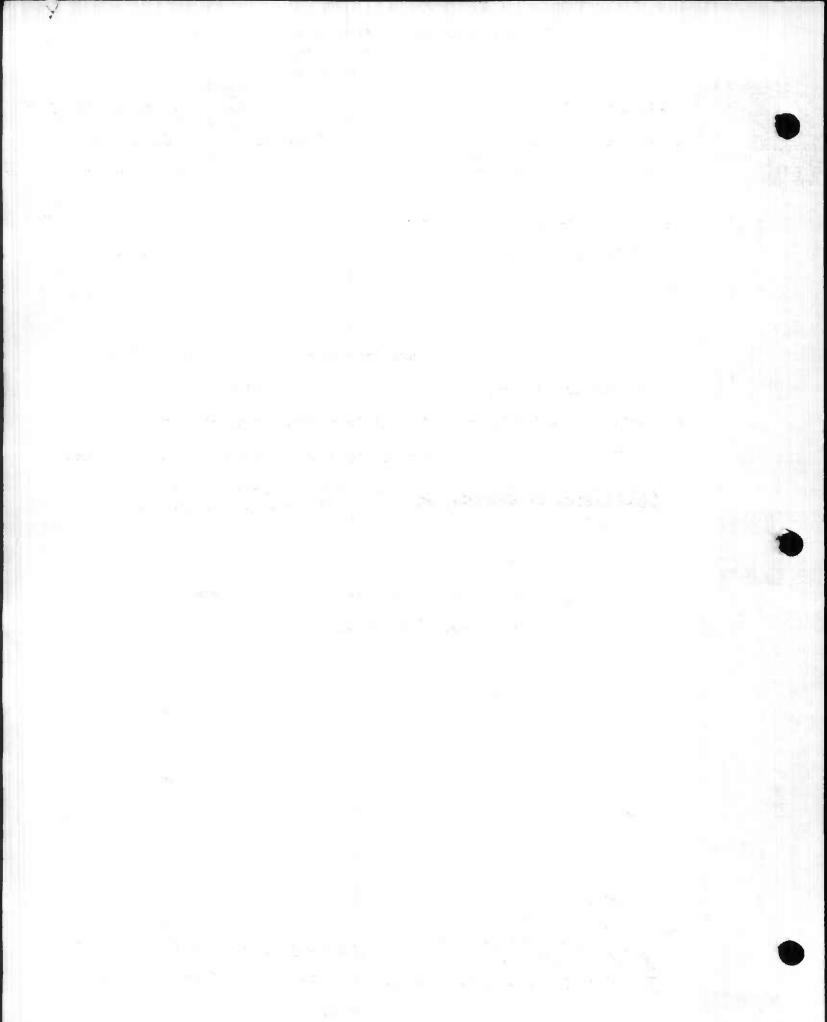
DHMH 16 Rev 6/95

State

FEB 0 9 2000

31. Dete filed (Month, Day, Yeer)

32. Registrer's Signeture



4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner 6. Sax BA SA T If Under 24 Hrs. 1/2 mo/e If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 10XM 2□ F 214-14-0634 FEB. Director 20, Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 28a-f ahow Examiner must be notified at Director MD BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code ð 2 HIGHSTEPPER COURT #104 21208 Нете 23а Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 (X) Yas 2 □ No If Yas, Giva Year or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Nevar Married 2 Married "natural", or WWII 1 ☐ Yes 2X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than ' Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 SALES MANAGER 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Known Be IRVIN SACHS IDA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Important: If item 27 is any injury or other trau DOLORES B. SACHS / WIFE 2 HIGHSTEPPER COURT #104 - BALTIMORE, MD 21208 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) **Department** BALTIMORE HEBREW CEMETERY 2/9/00 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ardiomyopathy /Medical Immediata Causa (Final diseasa or condition rasulting in daath) Examine Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disaasa or Injury that initiated evants rasulting In death) Last pue Dua to (or as a consequence of): Due to (or as a consequence of):

Sach

1. Decedant's Name (First, Middle, Last)

rome

2

Physician

/Medical

Box 68760. P.O. Records, Division of Vital

The law requires that the death certificate be execu use signed t has page 2 certificate or Attending Physician: this After death. 24 hours after deat Funeral Director:

Physician/Medical þ Completed Be Certification: To

edicai within 2. To the F

filled in by

Hospital

the

State Registrar

an 31. Data filed (Month, Day, Year)

10

2000

29b. Signature and title of certifier

25. Was casa ratarred to medical axaminar?

1 Yas 2 No

27. Mannar of Death

1 Natural
2 Accident

3 Suicida

29a. Certifiai (Check only

one)

4 Homicida

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Inpatiant

28a. Data of Injury (Month, Day Year)

Hospital:

5 Panding invastigation

6 Could not be datarmined

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Data of Death

February

Month

3. Time of Death

02:30

MD

10d. Inside City Limits

1 ☐ Yas 2 X No

N/A

Birthplace (Stata or Foreign Country)

U.S.A.

WHITE

Approximate Interval Between Onset and Death

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yas 2 □ No

Vear

0000

/4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, Stata

23b. Did tobacco use contribute to the cause of death?

1 Yas 2 No

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

26. Place of Death (Check only one)

REISTERSTOWN, MD

14. Race - American Indian. Black, Whita, etc.

MATTRESS MANUFACTURER

WASSERSTEIN

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

AS 2402321-RM2A 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

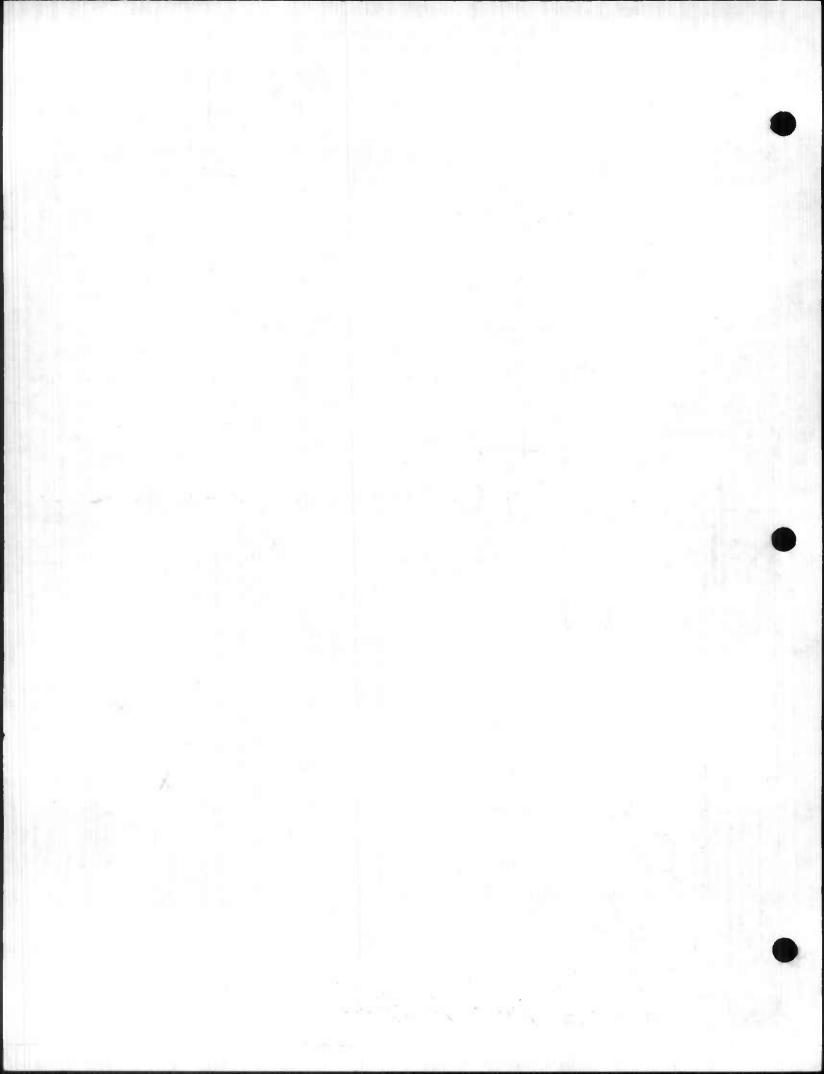
2 ER/Outpatient 3 DOA

28b. Time of

1001

32. Registrar's Signature

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. RICHARD E. STOKES SR. State of Maryland / Department of Health and Mental Hygiene ASP Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MOCH RUARY 07 2000 1:46 A Richard Edward Stokes, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
Virginia 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. **Funeral** Jan 08, 1937 1**X**) M 2□ F Months Days Hours 231-40-5695 63 Yrs. Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No 28e-f Directo N/A MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 finer must be 5515 The Alameda 21239 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No ff Yes, Give Year or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 72 hours after 1 Never Married Married "natural", or it adical Examin Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry be flied within 7 tal Hygiene. d other than "n went, the Med Elementary/Secondary (0-12) 12th College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental Health and Mental Health and Italians and Jury or other traumatic even 98 Henry Stokes Dosia Ausburn 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Stokes (Wife) 1756 E. Preston Street Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Department Copartment (Important: If any Injury or opper Mt. Zion Cemetery 2/11/2000 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Caple Funeral Service

Physician /Medical Examiner

The lew requires that the death certificate be executed

Attending Physician:

8

Hospital 24 hours

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star deeth. Director: Af d in by the fu

filled in

completely

within 2 \$

Medical

Box 68760.

of Vital Records, P.O.

Division

Examin

physicien and the burlai-transit Physician/Medical 080 aigned t à Completed 8 Certification: To funeral

Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was en autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

Approximate Onset and Death

Yes 2 No 26. Place of Death (Check only one)

Meres 2□ No

25. Was case referred to medical 1X Yes 2□ No 27. Manner of Death Netural 2 Accident

3 ☐ Suicide

29a. Certifier

4 \ Homicide

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury al Work? 1 Yes 2 No

28d. Describe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

5502 Winner Avenue Baltimore, Maryland 21215

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. (Check only 29b, Signal

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) FEBRUARY 07,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

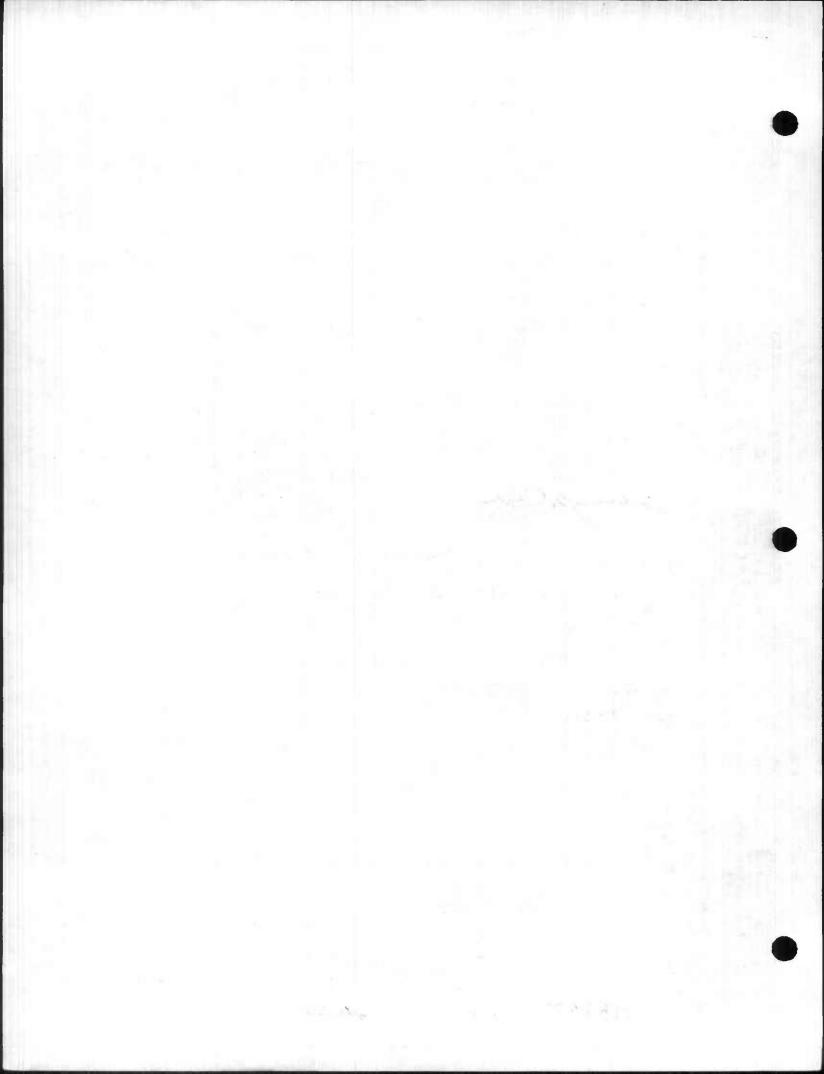
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2000

32. Registrar's Signature Jener

Docks

State Registrar



Funeral

Director

288-1

THANNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F PER MED C781 3-13-2000 WR.

Reg. No.

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Physician

/Medical

Examiner

physician and s the burial-trans certificate be 98 signed b Records, page 2 s this Affer Hospital or Attending death. a 24 hours after death.

• Funeral Director: A pletely filled in by the fi

Box 68760

P.O.

of Vital

Division

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year FEBRUARY 7, 2000 **Physician** Timothy 13:42 PM Gerard Thanner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner JOHN HOPKINS BAYVIEW N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/24/1952 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Days Hours 10XM 20XF Months 48 Baltimore 216-48-3452 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Md. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5515 Knell Avenue 21206 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Clerk Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Francis X. Thanner Mary Geary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 2113 Townhill Rd. Apt. C, Baltimore, Md. 21234 Donna Marie Thanner- Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removel from Stete Hilltop Service Corp. 2/10/2000 Towson, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Gary R. DiGiovant Name and Address of Facility Leonard J. Ruck Funeral Home Geranni 5305 Harford Rd. Baltimore, Md 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) SMOKE INHALATION Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 18 Yes 2 □ No 1 Yes 2□ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ₩ Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 2-7-2000 28d. Describe how injury occurred SUBJECT 27. Manner of Deeth 28b. Time of P 28c. Injury et Work? 5 Pending investigation 1 Natural 2 Accident 12:40 INVOLVED IN HOUSE FIRE 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
PRIVATE DWELLING 28f. Location (Street and Number of Rural Boute Number, City or Town, Stete) 5515 KNELL AVE. BALTIMORE, MARYLAND 4 Homicide edicai 29a. Certifier 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

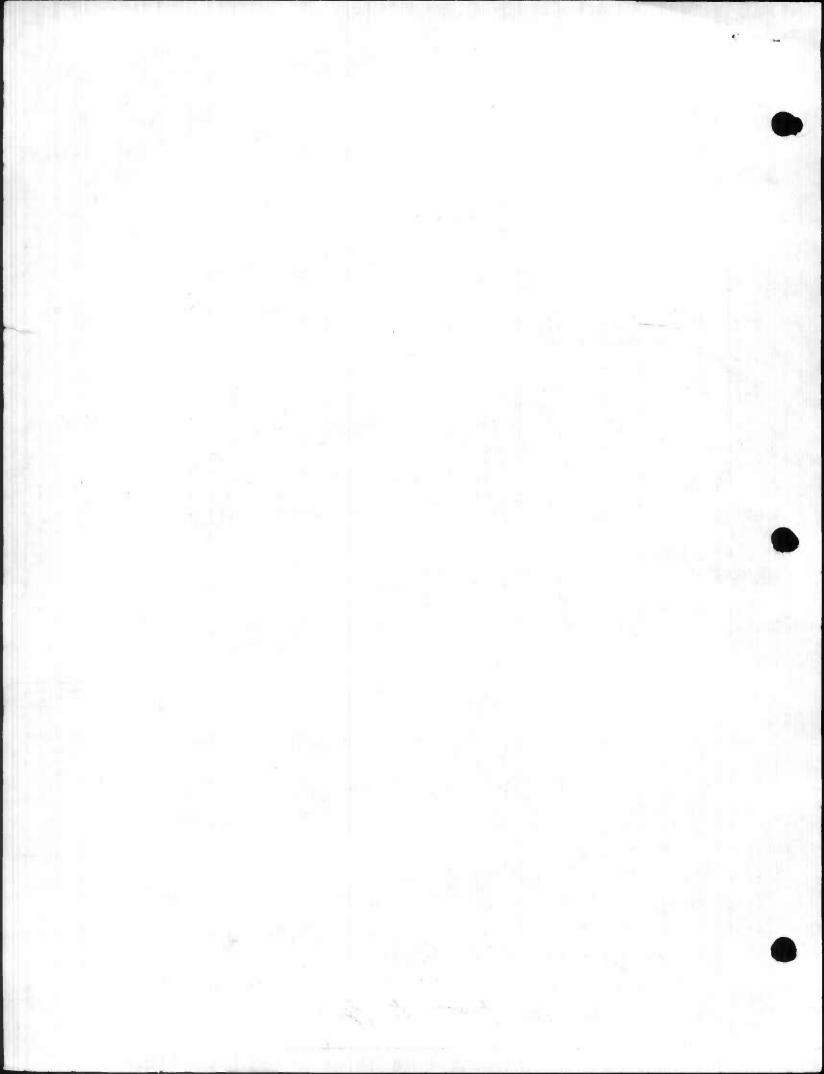
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number OCME FEBRUARY 07, 2000 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Radentz,
32. Register's Signeture 111 Penn Street, Baltimore, Maryland 21201 Stephen S.
31. Dete filed (Month, Day, Year) 5.

State

Registrar

FEB 10

To the Hosp within 24 hos To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Deeth 2. Dete of Death Month **Physician** RUDOLPH **EDWARD** TIGHE February 6, 4:00 A.M. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 607 Sussex Road Baltimore Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys 10 M 2□ F Months June 12, Director Indiana 212-20-8319 the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 234 607 Sussex Road 21286 U.S.A. death Herra 2 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indien permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item eny injury or other treumatic event, the Medical Eastwine Bleck, White, etc. 1 GYes 2 No If Yes, Giva Year or Dates: 1942–45 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Tax Attorney Legal 17. Father's Nama (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumema) Laura Alice Pirie Rudolph Edward Tighe 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janet Tighe (wife) 607 Sussex Road Baltimore, Maryland 21286 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetary, crematory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2-9-2000 Green Mount Crematory Baltimore, Maryland 21. Signature of Funerat Service Licensee 22. Name and Addrass of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each tine. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final · Metastatic Epidermoid Skin Caucer disease or condition resulting in death) Examiner Examiner physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or es a consequence of): Physician/Medical Dua to (or as a consequence of) for use es signed by the e Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this carifical eleicy filled in by the funeral director; 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ESNatural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 12-Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated. edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred at the time, date end piece, and due to the cause(s) and manner steted. 29b. Signeture end titte of certifie 29c. License number 29d. Date signed (Month, Dey, Year) no completed cause of death (Item 23a) (Type, Print) Raven Blud, Baltimore, MD 21239

State Registrar

Baltlmore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

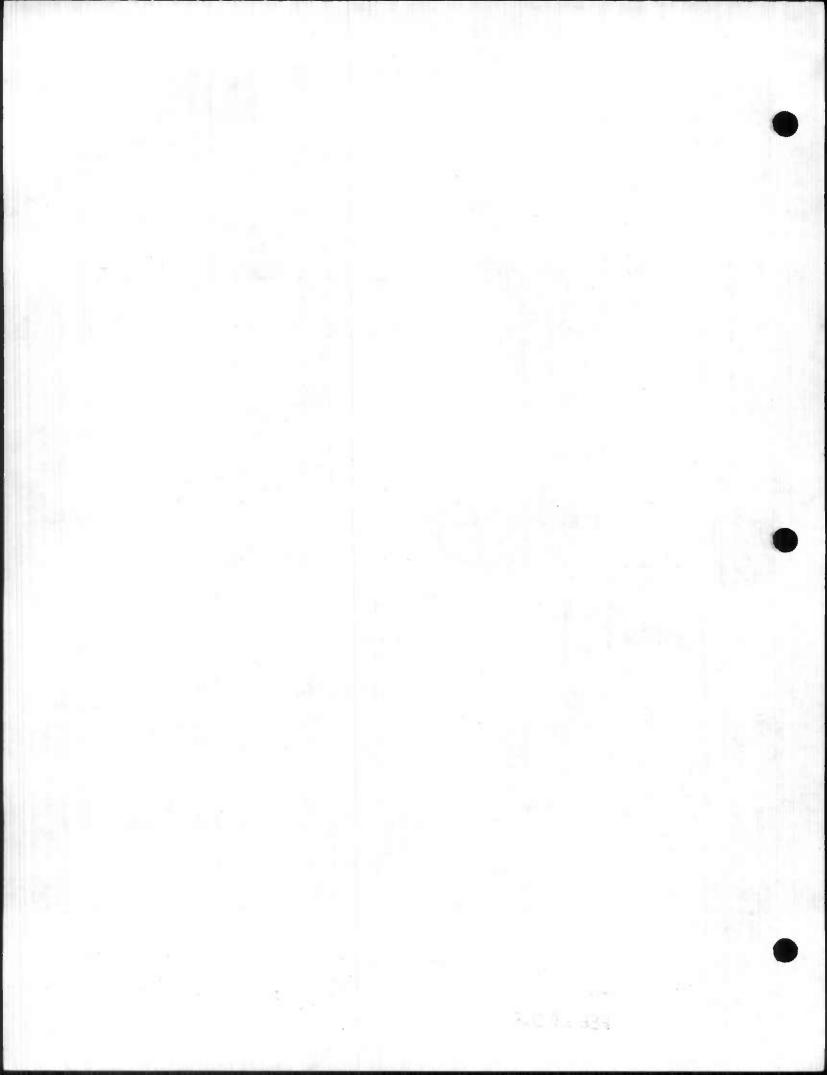
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32. Registrar's Signature

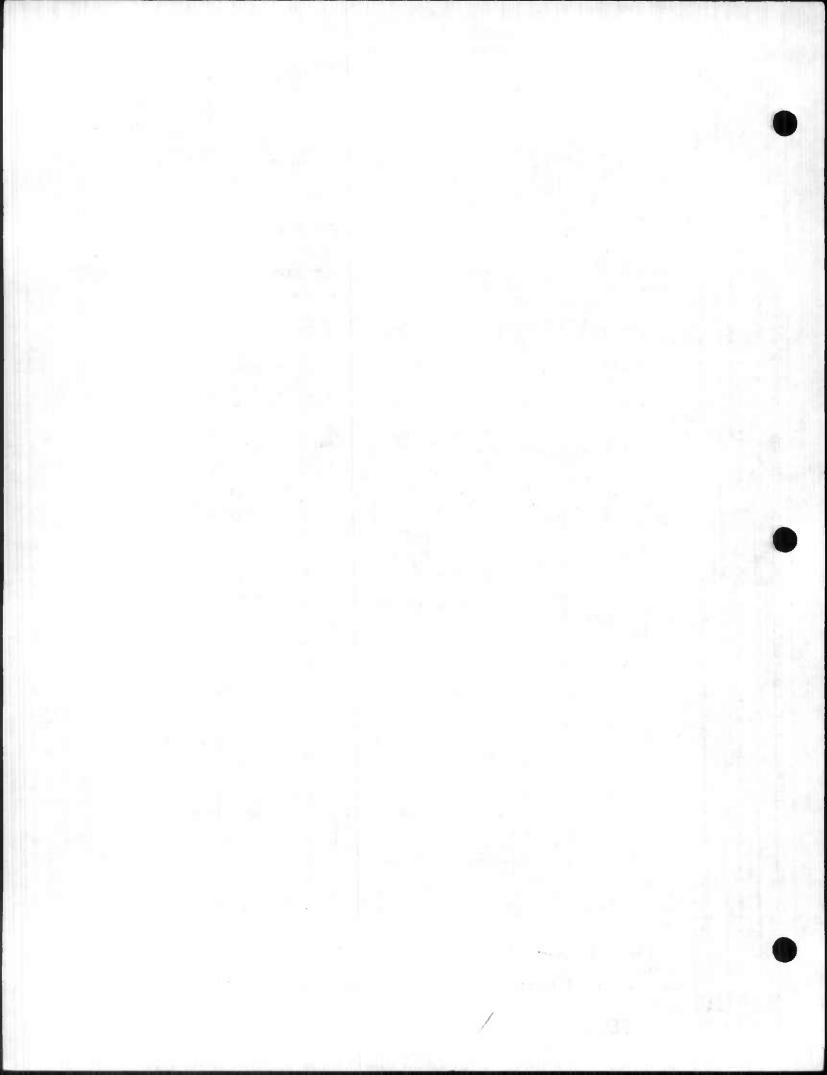


DHMH 16 Rev 6/95

2000

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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death - Month Year ebruary 5,2000 Neme (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. If Under 1 Yea 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Qountry) 6. Sex Days Months Hours 1 M 2 F Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Sfatus American Indien, Black, White, etc. 1 Never Merried 2 Married 2 No 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) | Continue of the 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Name /First. Middle, Meiden Sumame. 90 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sister to. enn 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State ery, crematory or other pleca) 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) 10h 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility 23a. Pent 1 Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md.Z Approximate Intervel Between Onset and Death Alkero Sciente Cardro varcula Disease Immediate Cause (Finel disease or condition resulting in deeth) Perpheral Vascular DISCOR Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequenca of) Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Naturel 5 Panding 1 TYes 2 □ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide

Examiner Examiner physician and s the buriel-transit been signed by should be detac Records, Division of Vital Attanding Physician: Certification: To To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune Medical

Physician

/Medical

Examiner

Funeral

Director

mark be notified at

'netural', or Items 23s or

hours after

filed within 72 h Hygiene.

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic avent pages.

Physician

/Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Physician/Medical þ Completed Be

> State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) FEB 1 0 2000

29e. Certifier

(Check only one)

29b. Signature and titla of certifier

Sabapathi 32. Registrer's Signeture

30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print)

821

1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner stated.

29c. License number

130641

29d. Date signed (Month, Day, Year)

February

N. Eutzus St #308 Bauto Na 21201

ORIGINAL

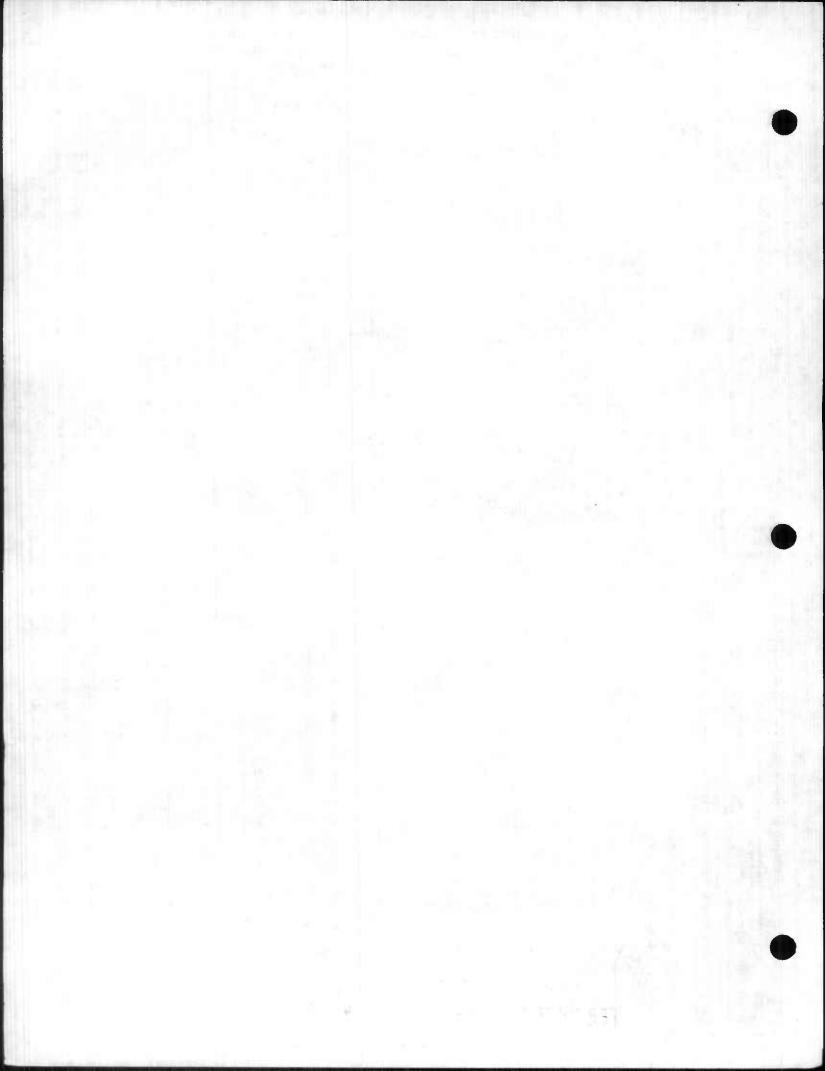
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State of Maryland / Department of Health and Mental Hygiene

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| | | C | ertificate of Death | Re | g. No. | |
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| Dhusisian | 1. Decedent's Neme (First, Middle, Last) | 2. Date of Death Month | Day Year | 3. Time of Death | | |
| Physician /Medical | TIMOTHY | | Williams | FEBRUARY | 03 2000 | 21:03 |
| Examiner | 4a Facility Name (If not in titution, give street | r Location of Death | 4c. County of Death | 1 | | |
| | THE JOHNS HOPKINS HOS | | BALTIMOI | | | |
| neral ector | 5. Social Security Number 6. Sex 21.7-76-6690 | 7. Age (In yrs. last birthdi | Months Days Hours Mir | | 79. Birth Cor. BA | pplace (State or Foreign intry) LTO • MD |
| 1 | Usuat Residence of Decedent 10a. State 10b. County | 10c. City, Town or | Location | | | 10d. Inside City Limits |
| at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director | MD N/A | | LTIMORE | | | 1 ☐ Yes 2 ☐ No |
| | 10e. Street and Number 10 CINNAMON CIRCLE | E 1.D | 101. Zip Code 21.133 | 10 | U.S.A. | intry? |
| | 11. Maritei Status 1 Never Married 2 Merried 1 Never Married 2 Merried 1 Never Married 2 Merried | | 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuben, Mexican, Pue 1 Yes 2 No Specify: | Specify Yes or No- irto Rican, etc.) | 14. Race - Amer Black, White Specify: | |
| Strate Delta | 15. Decedent's Education (Specify only highest grade comp | leted) 16a. De | cedent's Usuel Occupation ive kind of work done during most of w | rorkina 1 | 16b. Kind of Business/I | ndustry |
| ygene. wr than "nahun r, the Medical Completed | | llege (1-4or 5+) SEI | e. DO NOT use retired) | | | |
| Be C | 17. Father's Neme (First, Middle, Last) | | | eme (First, Middle, M | laiden Sumame) | |
| To | HARRY WILLIAMS | | LAURA | SPIVEY | | |
| or trauma | 19e. Informent's Neme/Relationship (Type, Pn CHERYL BLACK, NEIC | 1.00 | eiling Address (Street and Number or I 7 ROKEBY ROAD, | | | ip Code) |
| ary or othe | 20a. Mathod of Disposition 1 Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | 20b. Place of Di cemetery, MOUN | sposition (Name of crematory or other place) TZION | |) balto. | |
| Importa any inju paca. | 21. Signature of Funaral Service Licansee | 9 | 22. Name and Address of Facility HOWELL FUNERAL 4600 LIBERTY H | HOME | E, BALTO, | MD 21207 |
| | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause | s that caused the death. Do not | | | | Approximate Intervat Between |
| ician | Shock, of Heart failure. List only one caus | se on each line. | | | 1 | Onset and Death |
| dical | Immediate Ceuse (Finel diseese or condition | SR. DSO | | | | one week |
| iner | resulting in death) a | Due to (or as a con | sequence of): | | | ore vicere |
| Examiner | | pneumon | ×2 | | | one week |
| СВШ | Sequentially list conditions, | Die to (or as a con | | | | |
| | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c | Aute | send failuse | | | one well |
| ie as the bunal-transit Medicai Examir | thet initiated events resulting in death) Lest | Due to (or es e con: | | | | |
| 6 | d | Arguish & | mmure delivere | 2 Symprom | re | one year |
| / Physician/N | | + | | | I | |
| Physician | Part II. Other significant conditions contribution | ng to death but not resulting in th | e underlying cause given in Pert I. | 23b. Did tol | bacco use contributa | to the cause of death? |
| leted by Phy | | | | 1 🗆 Ye | a 22(No 3□Pr | obably 4 Unknown |
| Completed | | | | 24a. Wes an perform | ned? | Were autopsy findings available prior to completion of cause of death? |
| orrector, page 2 To Be Comp | | | | 1 ☐ Ye | - | 1 ☐ Yes 2 ☐ No |
| | 25. Was case referred to medical | | 26 Place of D | eath (Check only one | | 2100 20110 |
| o Be | axaminer? 1 Yes 2 No Hospita | 1: 1 Inpatient 2 ER/Outpa | Other: | | ince 6 Other (Spec | oiful |
| | 7 | Date of Injury 28b. Tim | e of 28c. tnjury at | 28d. Describe ho | | ary) |
| tlor | 1 Neturel 5 Pending investigation | (Month, Day Year) tnju | Work? M 1 Yes 2 No | | | |
| led in by the funera Certification: | 3 Suicide 6 Could not be determined 28e | reet and Number or Ru , State) | rel Route Number, | | | |
| Completely filled in by the funeral Medical Certification: | (Check only 2 Medical Examiner: Or | | eath occurred at the time, date and pla r investigation, in my opinion, deeth oc | | | |
| Me omple | 29b. Signeture and title of certifier | | 29c. License number | 25 | 9d. Date signed (Month | h, Day, Year) |
| 0 | I Just Muh | Resident | CES-0 | 00 F | chiusry Fr | uth 2000 |
| 0 | 30. Name and address of person who complete | | 11 11 16 | | | |
| V | Justin Mora | | nthe Wolfe. | | | |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | 4 las Vi | | | |

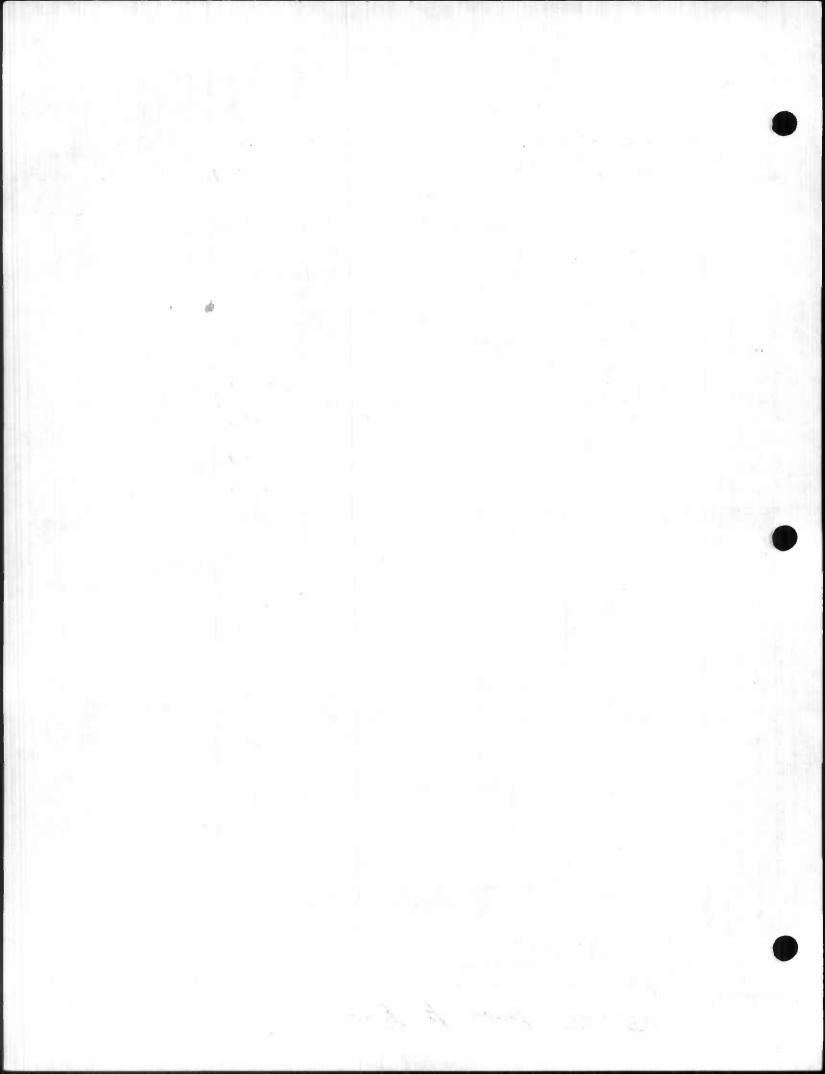


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** 31, Martha L. Wheeler Jan 2000 /Medical 5:35 P.M. 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Randallstown
If Under 24 Hrs. 8. Day Northwest Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2□F Director 129-22-6464 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. fnside City Limits mast be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7409 Shirley Road Funeral 21207 death USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hem any injury or other traumatic event, the pages. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: by 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hamemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Bailey Mamie Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie James 7409 Shirley Road Baltimore Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/7/00 Littleton Nc. 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disaase or condition resulting in death) /Medical Telminal hours Examiner Due to (or as a consequence of) Physician/Medical Examiner advanced The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Dua to (or as a consequence of): use as the P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2/X No 3 Probably 4 Unknown Vasculae Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 200 No 1 Yes 2 No certificate spital or Attending Physician: Theoris ster death.

neral Director: After this certificate filled in by the funeral director, pa Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32158 2/10/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Entaw St, suite 407, Baltimore, MD 21201 tarikhno Lyoten 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Douglas Edmond Wyrick February 2000 5:30 A.M. /Medical 4a Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 113 Camrose Avenue Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

August 31,1914

North Carolina 7. Age (In yrs. last birthday) **Funeral** Days 1X7M 2 F 244 24 2775 Yrs. 85 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Director Maryland N/A Baltimore or 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Camrose Avenue Berns 23a 21225 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. hours after 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give altimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 27 Physiere. Ther than 14, the Med filed within Elementery/Secondery (0-12) College (1-4or 5+) Painting Contractor Painting 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be hent of Health and Mental is marked Carrie Overby 2 Albert Wyrick 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Camrose Avenue Department of Health Important: If Item 27 Katie Wyrick Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Glen Haven Memorial Park 2/9/00 Glen Burnie, Maryland 4 ☐ Donellon 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. momunich 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical months Carcinoma of Oropharynx Examiner Due to (or as a consequence of): Examiner Coronary Artery Disease 12 years The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): physician is the burial Box 68760. Carcinoma of Prostate 12 years Physician/Medical Due to (or as a consequence of): 12 years Essential Hypertension P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Peripheral Vascular Disease signed to Records, þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? complation of cause of death? page 2 s 1 Yes ZONo 1 Yes 2 No of Vital Hospital or Attending Physician: 8 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 18 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Division 1 Neturel 5 Pending investigation s after death. 1 Yes 2 No 2 Accident in by the 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a Certifier completely (Check only one) within 2 ŝ 29b. Signature and title of pertifie 29c. License number 29d. Dete signed (Month, Day, Year) 02/08/2000 D14160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

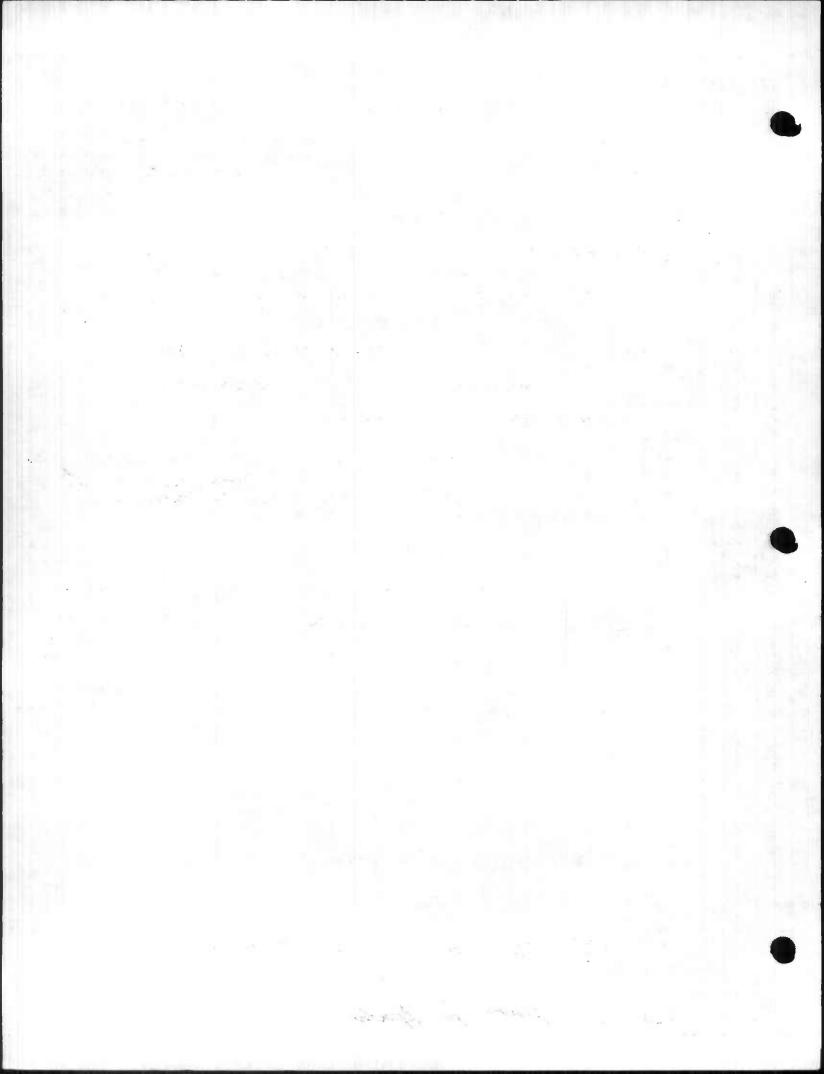
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Harjit Singh,

M.D.

5410-A Ritchie Highway Baltimore, Md. 21225 32. Registrer's Signature parks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 550 PM FEB 2000 MRBARA WILLIAMS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a ,Facility Name (If not institution, give street and number) Examiner ALTITURE HOSPITAL ERCY N/A 8. Date of Birth (Month, Day, Year) 1965 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 TF 215-74-2383 Maryland 34 Yrs. Usuat Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits MD. N/A t Yes 2 No **Baltimore** Director 10e. Street and Number 10f. Zip Code t0g. Citizen of What Country? 26 South Exeter Street Apt. F 21202 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1□ Yes 2 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Receptionist Telecommunication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zede Fullwood Candice Williams 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donita Davis (Daughter) 26 South Exeter Street Apt. F Balto, MD. 21202 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell's Memorial Grd 2/12/2000 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral S 5502 Winner Avenue Baltimore, Maryland 21215 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one ceuse on each line. Shock, or heart failure. Approximete Interval Between Onset and Deeth Immediate Cause (Final easis disease or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 □ Probably ≰K Unknown 1 Yes 2 No AIDS 9 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 25 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1-Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.O. Box 68760. tha death certificate be Records, Division of Vital Mospital or Attendi 24 hours after death. Funeral Director: A To the Hospi within 24 hou To the Funer completely fil

Funeral

Director

7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at

other 1

permit. Page Department of Important: If any injury or 8

Physician /Medical

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Pages 1 and 2 should be filled within 72 hours effer nent of Health and Mental Hygiene. nt: If item 27 is marked other than "naturel", or its

Baltimore, Maryland 21215-0020

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State Registrar

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29b. Signature and title of certifier

361 ST 32. Registrar's Signature

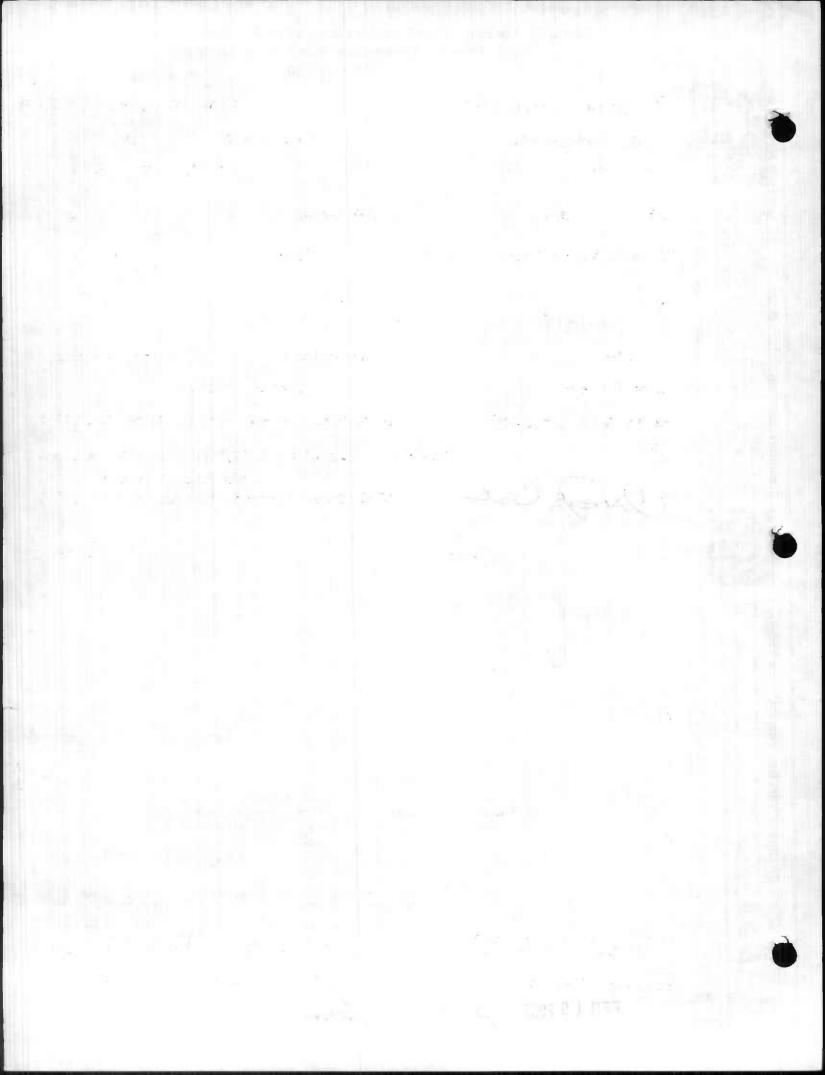
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

PAUL & LARE BACTIMONE

29c. License number

29d. Date signed (Month, Day, Year)

51202



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| | | | | Certificate of | Death | | Reg. No. | 0 | 70 |
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| husisian | 1. Decedant's Nama (First, Middla, Li | | | | | 2. Date of D Month | eath Day | Yaer 3 | . Tima of Death |
| hysician /Medical | David Quentin Ar | ndes | | | | Jan. | 21 200 | | 4:30 A.M |
| kaminer | 4e Facility Nema (If not institution, gir | ve street and number) | | | 4b. City, Town, o | | | | |
| | 8999 ST. ANDREW | | | | Chesapea | | | | |
| al or | 218 56 8420 | What off | (In yrs. last birl | thday) If Under 1 Yee Months Deys | | | rith (Pay, Year) 23, 1950 | Country) | gton D. |
| | Usual Rasidence of Decedant 10a. Stata 10b. County | | 10c. City, Town | or Location | | | | 104 | Inside City Limits |
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| Directo | Maryland Calvert | | Chesap | eake Beach | | | 10g. Citizen of V | | |
| | 8999 St. Andrews | Drive | | 2073 | | | | l State | |
| era | 11. Marital Stetus | 12. Was Decedant E | var in U.S. | | | Specify Yas or N | | - Amancen I | |
| by Funeral | 1 □ Nevar Married 2 ☐ Married 3 □ Widowed 4 □ Divorced | Armed Forcas? Ya Yas 2 N If Yes, Giva Yaar or Datas: | 0 | 13. Was Decedent of II Yas, specify Cu | | rto Rican, atc.) | Blac | k, Whita, atc. White | |
| Completed | 15. Decedent's E (Specify only highast gr Elamentary/Secondery (0-12) | ducetion ade completed) Collega (1-4or 5- | | Decedant's Usual Occi (Giva kind of work don- life. DO NOT usa retir | upation a during most of w red) | orking | 16b. Kind of Bu | sinass/Indust | try |
| Con | 12 | 0 | | us Driver | | | School | System | n |
| Be | 17. Father's Name (First, Middle, Last | | | | | | a, Maidan Sumam | a) | |
| 10 | Lawrence Andes, | Sr. | | | Olivia | Boyd | | | |
| | 19a. Intormant's Neme/Reletionship | (Type, Print) Wife | | Mailing Address (Street | | | | | |
| | | wile | | 999 St. And | | | | | |
| | 20e. Mathod of Disposition 1 Burlal 2 Carametion 3 C 4 Donation 5 Other (Speci | | | Disposition (Nama of y, cramatory or other pi opolitan Cr | ematory | | 20c. Location - | ria Vi | |
| | 21. Signetura di Funeral Sarvice Lice | 1000s |) | 22. Nama and Add Robert E. 16000 Ann | rass of Facility Evans F | uneral H | Home, Inc | d 2071 | - |
| niner | Immediate Cause (Finel disaase or condition resulting in death) | a | Dua to (or as a | consequence of): | | | | i i t | |
| edical Examiner | Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseesa or Injury thet Initiated evants resulting in daeth) Last | C | | consequence of): | | | | | |
| 95 | | d | | | | | | 1 | |
| Sicia | Part II. Other eignificant conditions | contributing to death bu | t not rasulting in | tha underlying ceusa g | givan In Part I. | 23b. Die | d tobacco use co | ntribute to th | e cause of death |
| by Physician/ | | | | | | 10 | Yee 25 No | 3 Probeb | ly 4□Unknow |
| Completed b | | | | | | | s an autopsy formed? | availa | autopsy lindings ble prior to letion of ceuse oth? |
| TOC | | | | | | 19 | PYas 2□No | 1094 | as 2 No |
| Be | 25. Was cesa rafarred to medicel examiner? | | | | | eath (Check only | ona) | | |
| To | 1 Yas 2 No | Hospital: 1 Inpatier | nt 2 ER/Ou | tpatient 3 DOA | Othar: 4 Nursing | Home 5 Re | sidance 6 00th | ar (Specify) | |
| Certification: | 27. Manner of Death 1 Netural 5 Panding 2 Accidant investigation 3 SY Suicida 6 Could not be | | Year) I | | iury et ork? Yas 25/No | subje | | sed | self |
| Certifi | 3 Suicida 6 Could not to datarmined | building etc. | ry - Al homa, la (Specify) 8 (AL \ C | rm, street, factory, offic | е | 281. Location City or T | (Street and Numb | oer or Rural R | outa Number, S ONVL |
| edicai | | nyelcian: To the best of miner: On the basis of the manny stat | examination en | | | | | | |
| ž | 29b. Signatura and titla ol certifiar | 14/ | | 29c. Lica | nsa number | | 29d. Data signe | d (Month, Day | y, Year) |
| | / | 1/4/ | | o.c. | M.E. | 1774 | JAN. 22 | , 2000 | |
| 100 | 30. Nama and address of person who David Fowler, M | | | (Type, Print) reet, Balti | more, Ma | ryland 2 | 21201 | | |
| State | 31. Data filed (Month, Gay, Year) | | r's Signatura | | | | | | |

Registrar

13 76 5

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January 24,2000 **Physician** Walter V. Blake 2:38 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Min 10 M 20 F Months Days Hours Maryland 218-20-0181 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, on Wedgest Emerican 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ЬM P.G. Capitol Hgts. 1 ▼Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6905 Avon St. 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give ¹ 44 − ¹ 46 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes XX No Specify: Black Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Safeway Food Stores 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Malden Sumame) Be Walter Blake Eleanora Oueen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Blake/Wife 6905 Avon St., Cap. Hgts., Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l. Mem. Park 1/31/00 Laurel, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. R ans 4925 Burroughs Ave., N.E., Wash., D.C. 20019 rall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner in Cerebra physician end s the burial-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. Typertension Dud to (or as a consequen Physician/Medical to (or as a consequence of) 80 esn 0 ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown Hydricyhlus Records, h ml filullation 24b. Were autopsy findings available prior to pluods Completed 24a. Was an autopsy periormed? completion of cause of death? page 2 hes 2 2 No pertensus 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 3□ DOA 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Detural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai pletely (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the T 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) JAN 2 7 2000

William Boyce

3001 Hosp Br Chevah 32. Registrar's Signature

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A September 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Norman January 23, 2000 10:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 23, 1929 9. Birthplace (State or Foreign Country)
Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months MM 2DF Yrs. 577-38-0364 70 Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No 9910 Chardal Lanham Directo Maryland Prince George's 23s or 28s-t 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 8910 Crandall Road 20706 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Hems 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dales: 1 Never Merried 2 Married 21215-0020 8 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☒ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 6 years College (1-4or 5+) Construction Worker Private Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Nem 27 is marked or any Injury or other traumatic eve Mary Elizabeth Randolph Joe Burr 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8910 Crandall Rd. Lanham, MD 20706 Thomas Burr - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e Method of Disposition Date 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 2/1/2000 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, MD 22. Name and Address of Facility 21. Sign lure of Funeral Service Licen Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Wash. D.C. 20019 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final lyocardial disease or condition resulting in death) Examiner Physician/Medical Examiner arter oronary 150450 The law requires that the death certificate be executed for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? yd bengis 3 Probably 4 thiknown 1 Yes 2 No Diabetic tretoacidosis Be Completed by 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director, 25. Was case referred termedical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 10 Inpatient 2 ER/Outpatient 3 DOA epital or Attending Phys nours after death. neral Director: After this of filled in by the funeral di this 27. Manner of Death Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier and title of certifier 29b. Signatum 29c. License number 29d. Date signed, (Month, Day, Year) Frimail M. D. 24100 DO053813 Clinton MD and address of person who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2000

DHMH 16 Rav 6/95

Registrar

JANE 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Certifica | ate of Death | Be | ig. No. | 040/6 |
|--|--|---|--|--|--|-------------------|--|
| , Dharaisina | 1. Decedent's Name (First, Middle, Las | 4) | | | 2. Date of Death | | 3. Tima of Death |
| Physician /Medical | FLORENCE BURN | ETTE | | | January | | |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | 4b. City, Town, | or Location of Death | 4c. County o | f Death |
| | HCR * Manor Care | / Largo | | Largo | | Prince | e George's |
| Funeral Director | 5. Social Security Number 424-12-2467 Usual Residence of Decedent | 7. Age (In yrs | s. last birthday) If Un Month | der 1 Year If Under 24 H ns Days Hours M | | | 9. Birthplace (State or Foreign Country) nniston, Alabama |
| 2 | 10a. State 10b. County | 10c. C | ity, Town or Location | | | | 10d. Inside City Limits |
| the Maryland 28s-f show bottlisd.st sector | Maryland Prince Geo | | ple Hills | | | | TØ Yes 2 □ No |
| or 28s-f se notified | 10e. Street and Number | 190 5 | | Zip Code | 10 | Da. Citizen of Wi | hat Country? |
| | 3206 Culver Street | | | 20748 | 1 | United S | States |
| 5-0020 72 hours after death values; or Herne 23 fileal Examiner must | 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. Wes Decedent Ever in It Armed Forces? 1 Yes 2 ANO If Yes, Give Year or Dates: | If Yes, s | cedent of Hispanic Origin? pecify Cuban, Mexican, Pu 2 2 X No Specify: | (Specify Yes or No- erto Rican, etc.) | Bleck, | - American Indien, , Whita, etc. Black |
| 5-C | 15. Decedent's Ed (Specify only highest grad | | 16a. Decedent's U | sual Occupation | working 1 | 16b. Kind of Bus | iness/Industry |
| T21 | Elementary/Secondary (0-12) 12 years | College (1-4or 5+) | | work done during most of v ruse retired) maker | ionally | Private | 2 |
| Ind 2 | 17. Father's Name (First, Middle, Last) | | | 18. Mother's N | lame (First, Middle, N | laiden Surneme |) |
| Vian Wental Ment | Richard J. Wilson | | | Della | Kirby | | |
| C should and Men and M | 19a. Informant's Name/Relationship (7 | ype, Print) | 19b. Mailing Addr | ess (Street and Number or | Rural Route Number, | City or Town, S | State, Zip Code) |
| | Nellie Lee - Daug | hter | 3206 Cul | ver St. Temp | le Hills, | MD 2074 | 18 |
| O -755 | 20a. Method of Disposition | 20b. | Place of Disposition (/ | Name of | | | City or Town, Stete |
| Pages nert of the rry or of | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ | Hemovel Irom State | cometery, cremetory o | 11,1114 | 1 /20 /2000 | Pronter | backwed boo |
| altim mit. Pag parment portant: y injury of | 21. Signature of Funeral Service Ligeny | | ort Lincoln | and Address of Fecility | 1/29/2000 | prentwo | ood, Maryland |
| D Per | Photo | Home | AA | Benning Roa | | | Home, Inc. |
| | 23a. Part 1 Amor the disease, or comp | lications that caused the dea | th. Do not enter the m | node of dying, such es card | liac or respiretory erre | st, | Approximate Interval Between |
| Physician | 3 | TO GROUP OF THE | | | | | Onset end Deeth |
| /Medical | Immediate Cause (Final disease or condition | Atheroscle | r Heart Di | 20350 | | | Years |
| Examiner | resulting in death) | a | (or as a consequence | | | | Tears |
| <u> </u> | | | | ascular Dise | ase | | Years |
| os/bu, cate be executed physicien and s the burlet-transit | Sequentially list conditions | b | or as a consequence of | | | | |
| EX GE EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Diabetes M | | | | | Years |
| ifficate be exampled by the purision of the pu | that initiated events | C. Due to (| or as a consequence of | 0: | | | |
| F 00 F | resulting in death) Last | | | ., | | | |
| BOX eath cent for use | | d | | | | | 1 |
| et the death ce dby the attendies etsched for use | Part II. Other significant conditions co | ntributing to death but not re- | sulting in the underlyin | g cause given in Pert I. | 23b. Did to | bacco use cont | tribute to the cause of death? |
| res that the de ligned by the a deteched if by Physic | | | | | 1 🗆 Ye | s 28 No | 3 Probably 4 Unknow |
| E XD . | | | | | | | |
| or o | | | | | 24a. Was er perform | | 24b. Were autopsy lindings available prior to completion of cause of death? |
| The law ate has b page 2 alo | | | | | | - D. | |
| = F # 8 0 | | | | | 1 □ Ye | | 1 ☐ Yes 2 ☐ No |
| VITALI siclen: T certificat irector, p | 25. Wes case referred to medical examiner? | Hospital: | | Other | Deeth (Check only one | | |
| To state of | TU Yes 2DINO | 1 LI Inpatient 2 L | 1 | DOA 461 Nursing | Home 5 Reside | | |
| After funer funer | 27. Manner of Death 12 Natural 5 Pending | 28a. Date of trijury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe ho | w injury occurre | d |
| 2 2 2 2 2 | 2 Accident investigation 3 Suicide 6 Could not be | | М | 1 Yes 2 No | | | |
| or Attended of the control of the co | 4 Homicide determined | 28e. Place of triury - At h building, etc. (Speci | nome, ferm, street, fact ify) | tory, office | 281. Location (Str City or Town | | r or Rural Route Number, |
| D SESS O | | | | | | | |
| he Hospi in 24 hou he Funer pletely fill edical | (Check only 2 Medical Exam | reician: To the best of my kno iner: On the basis of examina | owledge, death occurrention and/or investigation | ed at the time, date end pla | ce, end due to the ca | use(s) and man | ner as stated. |
| To the Hospital or Att within 24 hours shad To the Funeral Direct Completely filled in by the Medical Certific | ane) | and manner stated. | | | | | |
| With Toth | 29b. Signature and title of certifier | 1 1 | | 29c. License number | | d. Date signed | (Month, Day, Year) |
| (.) | 1 Kakus | harda | 1-11) | 720 | 108 | 1/2 | 4100 |
| (4) | 30. Name and address of person who c | | | - 011 000 | D' 15 | 20715 | - 1 |
| U | Rakesh Arora, M.D |). 14300 Galla | ant Fox Lan | e Suite 222 | ROMIE, WD | 20715 | |
| State Registrar | 31. Date filed (Month, Day, Year) JAN 2 7 2000 | 32. Registrar's Sign | ature | | | | |

JAN 2 7 2000

Section .

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Yaar Month **Physician** Glendon Charles 21, Bickford 2000 5:45 pm January /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Hours 1♥ M 2□ F 69 Yrs. Sept. 13, 1930 Director 007-24-5817 Maine Usual Rasidence of Decedant the Menyland 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Vas 2 No Directo Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 27-B Ridge Road 20770 Herns 23a U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☒ Yas 2 ☐ No If Yas, Giva 1.0 / 0.5 14. Race - American Indian, 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. filed within 72 hours effer Hygiene. ther than "natural", or ite 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White P 3 Widowed 4 Divorced Yaar or Dates: 1949-52 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled with Department or Health and Mental Hygient Important: if item 27 is marked other that any injury or other treumatic event, that ones. Barber Barber Industry 17. Father's Nama (First, Middla, Last) 16. Mother's Name (First, Middle, Maiden Sumama) Be (Unavailable) Bickford (Unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Josepha Bickford - Wife 27-B Ridge Road, Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 Buriel 2 Cremetion 3 Ramoval from State MD National Memorial Park 01/26/00 Laurel, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21 Signature of Funaral Sarvice Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Examiner certificate be executed and Sequantially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Last ettending physician Box 68760 Physician/Medical the to (or as a consequence of) 9SD 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 100 signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen page 2 s 994 1 Yas 2 No 1 Yas 2 No certificate or Attending Physician: director. Be 25. Was casa refarred to medical examinar? 26. Place of Death (Check only one) 1 Yas 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mennes of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury st Work? After 5 Pending invastigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. (Check only one) Within 2. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signaffine and to 3 30. Name and use of death (Ite 31. Deta filed (Month, Day, Year) 32. Registrar's Signatura State JAN 2 2000 7 Registrar

1995 " S HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene SP/ACZMZN Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ruth Marion Baltzell 21, 2000 12:12 pm January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2♥F 79 Yrs 228-18-4876 May 21, 1920 **Director** Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 234 5409 Riverdale Road U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Hems 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) polimit. Pages 1 and 2 should be file Department of Health and Mernal Hy Reportant: If Nem 27 is marked oth any Injury or other treumstic even once. John Joseph Robinson Minnie Estell Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ethel Bolton - Sister 5409-B Riverdale Road, #B-1, Riverdale, MD 20737 20b. Placa of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2/3/00 Arlington, Virginia 21-Signature of Fundral Service Licensee 22. Name and Address of Facility
Gasch's Funeral Home, P.A. owll 4739 Baltimore Avenue, Hyattsville, MD 20781 Dan W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Chronic Obstructive Pulmonary Disease Examiner Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pur Due to (or as a consequence of) 68760. as the t Due to (or as a consequence of): Box (US8 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 X Yas 2 No 3 Probably 4 Unknown Anemia: Diverticulitis of Vital Records, by ed bluode 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? Hypokalemia; Hypertension 90ad 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Urinary Tract Infection Attending Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Affer Division 1 Natural 5 Pending investigation of or Attending after death.

I Director: After din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1\(\infty\) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner as stated.

2\(\sum \) Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) and menner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier D29671 February 18, 2000 30. Neme and address of person who completed cause of degfh (Item 23a) (Type, Print) Villamor S. Reyes, M.D. 6501 Landover Road, Cheverly, Maryland 20785-1414 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Ce | ertificat | te of | Death | | | Reg. No | LU-L | U | 401 |) |
|--|------------------|---|----------|------------------------|-----------------------------|---------------------------|----------------------------|--------------------|-----------------------------|-----------------|------------------------------------|----------------------|-----------|------------|--|------------|
| Discordada. | | 1. Decedent's Nama (First, Midd | le, Last |) | | | | | | | 2. Date of Do | eath Da | | Year | 3. Time of I | Death |
| Physicia /Medic | - | | D | onald | K. B | axter | | | | | Jan. | 18, | 20 | | 7:00 | P.M |
| Examin | | 4a Facility Name (If not institution | n, give | street and no | ımber) | | | | 4b. City, To | wn, or L | ocation of Deal | - | | of Death | | |
| | | Chesapeake 1 | Hos | pice | House | | | | Lint | hic | um | A | nne | Aru | ndel | |
| Funeral | | 5. Sociel Sacurity Number | 6. Se | _ | 7. Age (In yr. | s. last birthda | /) If Unde | 1 Year Days | | 24 Hrs. Min. | 8. Date of Bi | rth | | 9. Birth | place (State or | Foreign |
| Director | - | 007-34-0837 | 1X |]M 2□F | 76 | Yrs. | Months | Days | nours | IVIII. | 10-23 | -19 | 23 | | ada | |
| 2 | - | Usual Residence of Dacedent | | | | | | | | | | | | | | |
| nylar show | | 10a. State 10b. County | | | | City, Town or | Location | | | | | | | 1 | IOd. inside City | |
| W I | 용 | Md. Anne | Ar | undel | . C | rofto | n | | | | | | | | 1 Yas | 2 No |
| 5 6 | S e | 10e. Street and Number | | | | | 10f. Zi | Code | | | | 10g. Cit | izen of V | Vhat Cour | ntry? | |
| 23 B | <u>a</u> | 1711 Greent: | ree | Cour | t | | | 2 | 21114 | | | U | SA | | | |
| 11215-0020 within 72 hours after death with the Manyland ene. than "natural", or Nems 23s or 28s-f show the Weddell Examinat must be notified at | Funeral Director | 11. Marital Status | | 12. Was Dec Armed F | edent Evar in orces? | U,S. 13 | . Was Dece | dent of I | Hispanic Or | igin? (Sp | ecity Yas or No Rican, etc.) | 0- | | e - Americ | can Indian, | |
| o se se | E | 1 Never Married 2 Mar | | 1 ☐ Yas If Yes, G | 2₽ No | | 1 ☐ Yes | | | | | | | 1 | | |
| 21215-0020 d within 72 hours al piena. rr than "natural", or rr than "natural", or | dby | 3 Widowed 4 Divorced | 1 | Year or I | | | | -X | | | | | Specify | Wh: | rte | |
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| within one. | de l | Elementary/Secondary (0-12) | | College | 1-4or 5+) | Chie | PO NOTE | se Perra | ødůct | S | | | | | | |
| A SOF | ၓၟႄႜ | | | 4 | | Acc | epta | nce | | | | | Go | | | |
| and 212. be filed within that Hygiene. d other than | Be | 17. Father's Name (First, Middle, | | | | | | | | | e (First, Middle | | | | | |
| aryland 2 should be filed and Mental Hygi marked other umatic event, it | 2 | George B. | Baz | xter | | | | | Mai | rgar | et E. | Gra | isse | | | |
| | | 19a, informant's Name/Reletions | hlp (Ty | rpe, Print) | | 100000 | | | | | at Route Numb | | | | | |
| | | David G. Bax | te | r - s | | | | | t Hig | _ | nds C | | | | | 0147 |
| Baltimore, semit. Pages 1 ar Department of Nea Important: If item 2 any Injury or other ance. | 1 | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3 MB | lemoval from | | Placa of Disposerry, cr | oosition (Ne emetory or | me of other ple | ca) | 0. | 1-19-0 | 0 ^{20c. Lo} | ocation - | City or To | own, State | |
| Pages Pages ment of mrt: If its ury or o | | 4 Donation 5 Other (S | | | Me | tropo | litar | Cr | emat | ory | | Ale | xand | dria | , VA. | |
| Balt permit. Departr Importa | | 21. Signature of Funaral Service | Licens | 9/1/18 | 20130 | 1 | 22. Name a | nd Addre | ess of Facili | ty Re | eall F | une | ral | Hom | 6 | |
| 00 82558 | | Robert G. | Be | all | M000: | 25 | 6512 | N.W | . Cr | | Hwy., | | | | | 1.5 |
| | | 23a. Part1. Enter the disaase, or | compl | ications that | caused the de | | | | | | | | | - | Approximate | |
| Physician | | shock, or heert failure. List | only or | na cause on | each line. | | | | | | | | | 1 | interval Betw Onset and D | |
| /Medical | | immediata Cause (Final | | | P | anc | ~ | Site | C | hac | 90 | | | 1 | Man | H |
| Examiner | | disease or condition resulting in death) | | | Due to | (or as a cons | | | | | | - | | 10 |) 1000- |) |
| | je l | | | | 200 10 | (0) 83 8 0013 | equerica or, | | | | | | | 1 | | |
| 58760, icate be asscuted physician and s the burial-transit | Examiner | Cognosticity list conditions | C 1 | 0 | Due to | (or as a cons | equence of) | | | | | | | 1 | | |
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| cords, P.O | 2 | | | | | | | | | | 24a. Wa | | psy | 24b. W | era autopsy fi | ndings |
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| Records, The law requires that has been signe page 2 should be | Completed | | | | | | | | | | | V | | | | |
| Vital Files The certificate rector, pag | | DE Was against to medical | 1 1 | | | | | | | | | | No | 11 | □Yes 2/21 | 40 |
| of Vita Physician: this certific ral director, | o ne | 25. Was case referred to medica axaminar? | - | lospital: | | D | | . Ot | her | | th (Check only | | | | HOSPI | ol |
| Phys raidis | - - | 1 Yes 2 No 27. Menner of Death | | 1 1 | | ☐ ER/Outpati 28b. Time | | DA | 4 LI N | ursing Ho | ome 5 Res | | | | 170 | use |
| After fune | | 1 ☑Natural 5 ☐ Pendir | | (Mor | of Injury oth, Dey Year) | Injury | м | 28c. inju Wo | rk? Yes 2□ | No | 200. 200000 | now inju | iy 0000ii | | | |
| VISION Attending or death. ector: After by the fune | Ca | 3 Suicida 6 Could | not be | Ole Plea | a of Injury - At | home (our c | | | 7105 2 | 140 | 29f Location | (Ctrant or | nd Numb | or or Dur | al Route Numb | |
| DIVISION Of or Attending Physister death. Director: After this 3 in by the funeral of | Certification: | 4 ☐ Homicide determ | ined | build | ing, etc. (Spec | cify) | areet, rector | y, onice | | | City or To | | | or or more | ar riodie reditie | · · |
| lette pres filled | | 29e. Certifier 17 Certifyin | a Dhu | delen. To the | heat of mula | | th account | - 4 4h - 4' | | d = 1 | | | | | | |
| Hos Fun Staly | edicai | (Check only 2 Medicat | Exami | ner: On the b | asis of examin | netion and/or i | nvestigetion | i, in my | me, date ar opinion, des | ith occur | and due to the red at the time. | , date and | d placa, | and due t | o the cause(s) | |
| | | 29b. Signature and title of cartifie | r - | and mar | ner stated. | | 29 | c. Licens | se number | | | 29d. Da | te sione | d (Month | Day, Year) | |
| F3F8 | | 1/1.0 | 1 | M | - () | CM | | |) 7 | 20. | 28 | | 1 | 21 | 00 | |
| (10) | - | June | V | 1-1 | مس | 7 | | 4 | | | | | 1 | | | |
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| State Registra | <i>-</i> | JAN 2 4 20 | | 2 | م مدر | 4 | 1 | | | | | | / | | | |
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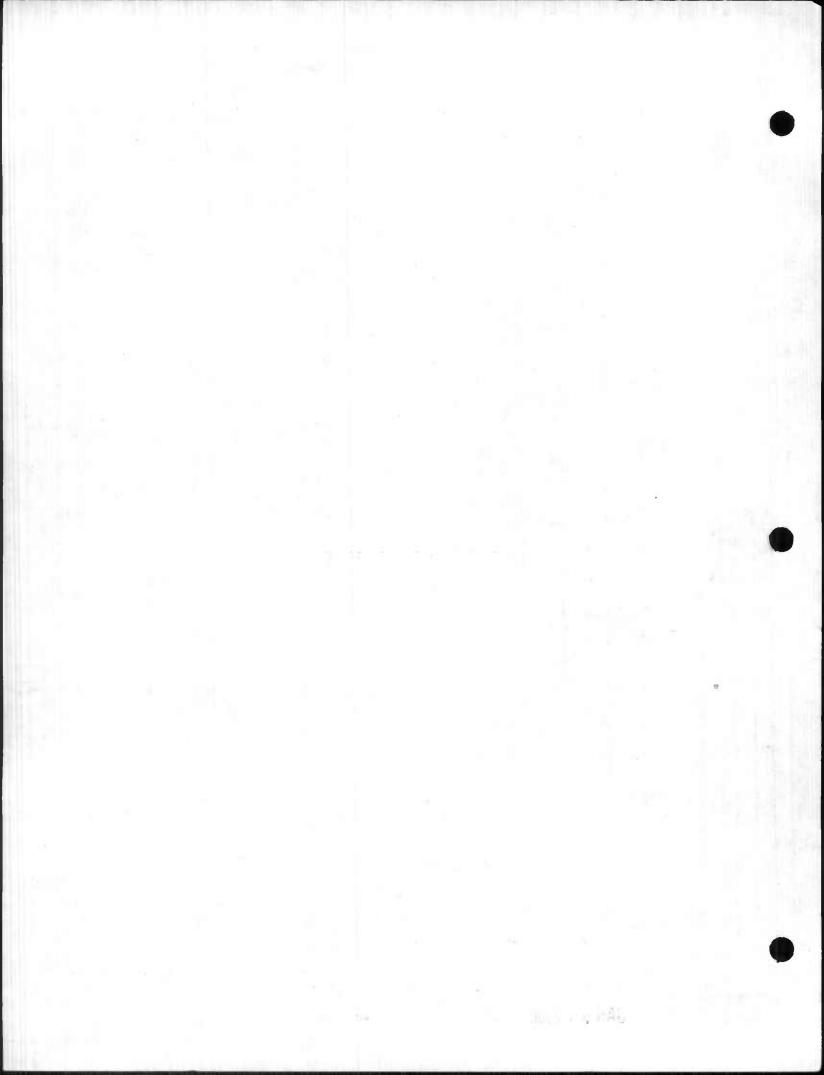
| 4 | | State of Marylan | | inment of the tificate of | | nentai Hy | glene Reg. No. | 10 | 04080 |
|--|--|--|----------------------------------|--|---|------------------------------------|------------------------------------|--------------------------------------|---|
| Dhualaian | 1. Decedent's Name (First, Middle, Las | U) | | | | 2. Date of De Month | eath Day | Year | 3. Time of Death |
| Physician /Medical | Carson Bi | rleson | | | | Jan | | 000 | 1:45pm |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or L | ocation of Deat | | | |
| | SHADY GROVE A | DVENTIST HO | SPITAI | C . | ROCKVILI | E | MON | I GOME | ERY |
| Funeral Director | 412-20-3490 | 7. Age (In yrs. 74 | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bi | th Year) 29 25 | 9. Birthpli Count | ace (State or Foreign |
| D B | Usual Residence of Decedent 10a. State 10b. County | 10c Cd | ly. Town or Lo | ration | | | | 10 | d Innido City Limite |
| a-f sho diffed at | 143 | | rmanto | | | | | | d. Inside City Limits 1 → Yes 2 → No |
| viih the Ma t or 28a-f s be notified | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of V | What Count | ry? |
| | | Lane | | 20874 | 1 | | USA | | |
| 0020 tours after death v unst', or thems 25s at Examiner mant d by Furneral | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U Armed Forces? XIXYes 2 No If Yes, Give Year or Dates: 1946 | H | Vas Decedent of N Yes, specify Cub | dispanic Origin? (Sp an, Mexican, Puerto Specify: | ecity Yes or No Rican, etc.) | Blac | e - America ck, White, e White | tc. |
| 5-0-5 | 15. Decedent's Ed | | 16a. Deced | ent's Usual Occup | pation during most of work d) | ina | 16b. Kind of Bu | usiness/Indi | ustry |
| Maryland 21215-0020 32 should be filed within 72 hours at the and Mental Hygiens "natures", or treatmetic event, the Medical Exam To Be Completed by I | Elementary/Secondary (0-12) | College (1-4or 5+) | | o Mecha | | u ny | Retail | Auto | o Repair |
| De de la contra del contra de la contra del la contra de la contra de la contra del | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | e (First, Middle | , Maiden Sumam | re) | |
| Aleman Mental Me | | on | | | Anna Ma | e Hone | ycutt | | |
| S S S S S S S S S S S S S S S S S S S | 19a. Informant's Name/Relationship (7 | ype, Print) | 19b. Mailin | g Address (Street | and Number or Rur | | | State, Zip | Code) |
| M Spings | Patricia Burles | son/wife | 1763 | 2 Burde | ette Lan | e.Germ | nantown | . Md . | 20874 |
| of the state | 20a. Method of Disposition | | Placa of Dispos | sition (Name of natory or other pla | | Date | 20c. Location - | | |
| Baltimore semit. Pages 1: semit. Pages 1: mportant: if hen my injury or othe mas. | 1 Burial 2 Cremetion 3 1 Donation - Copecity | Hemoval from State | | 's Ceme | | /29/00 | Rockv | i11a | БМ |
| Harry a | 21. Signature of Funeral Service Licent | | | Name and Addre | - 1 | /25/00 | ROCKV | TITE | , rid. |
| W FORES | 1 (was) | - | Du | nn & Sc | ns 5635 | Eads | St. NE | DC : | 20019 |
| Dhysisian | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused the deat ne cause on each line. | h. Do not ente | er the mode of dyi | ng, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Onsel and Death |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | · CONGEST | 118 | HE AR | T FA | LURE | E | 3 | Wecks |
| | resouring in dealer) | Due to (d | r as a conseq | uence of): | | | | I | |
| 8 # E | | COROSAM | 4 A | 11-1524 | DISE | TE | | 1 |) years |
| 60, be associted letan and burial-transit al Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (o | or as e consequ | uence of): | | | | | |
| 0 8 8 8 0 Te | Cause (Disease or injury | C | | | | | | | |
| physicate the the | that initiated events resulting in death) Last | Due to (o | r as a consequ | uence of): | | | | | |
| | W. W. H. P. L. | d | | | | | | | |
| e ettending of for use a | | | | | | | | 1 | |
| the de sched in Velo | Part II. Other significant conditions co | ntributing to death but not res | ulting in the un | derlying cause gi | ven in Part I. | 23b. Did | tobacco use con | ntribute 10 | the cause of death? |
| as that the de igned by the be detached by Physic | Chronic Obs | tructive 1. |) 4 /moi | many L |) iscase | 1 🖸 | Yes 2□ No | 3 Prob | ably 4 ☐ Unknown |
| requir requir should | Diabets 1 | Me 11. hua | | | | | an autopsy ormed? | con | re autopsy findings ilable prior to apletion of cause |
| The law ate has begge 2 a | Hyper kn | 2 con | | | | 10 | Yes 2DNo | | léath? Yes 2□ No |
| r Vital I yelcien: The s certificate director, per | 25. Was case referred to medicat examiner? | | | | 26. Placa of Deat | h (Check only | one) | 1 | |
| _ 5 .5 | 1 Yes 2 No | Hospital: 1 Impatient 2 | ER/Outpatient | 3□ DOA Ott | ner: 4 Nursing Ho | me 5 Resi | idence 6 Oth | er (Specify, |) |
| Affect For | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | ry at rk? Yes 2 ☐ No | 28d. Describe | how injury occur | red | |
| Division of the formal of the | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Placa of Injury - At he building, etc. (Specifical Control of the Control of | ome, farm, stre | et, factory, office | | 281. Location (City or To | (Street and Numb wn, State) | er or Aural | Route Number, |
| Hospi 14 hour Funer tely fill | 29a. Certifier (Check only 2 Medical Exam | eiclen: To the best of my kno- ner: On the basis of examinal and manner stated. | wledge, death tion and/or inv | occurred at the til estigation, in my o | me, date and place, opinion, death occur | and due to the red at the time, | cause(s) and ma date and placa, | nner as sta and due to | iled. the cause(s) |
| To the within 2 To the comple | 29b. Signatury and title of certifier | - Julion | | 29c. Licens | se number | | 29d. Date signer | d (Month, D | Pay, Year) |
| F 5 F 6 | V2/11/11 | me 1. | MIN | D. | 1154- | | TAZI | 75 | 7.171111 |
| F | 20 1000 | o way | 140 | 1/ | 16270 | | 37170 | | |
| (2) | (110) | ompleted cause of death (Item | 77 C | Frede | ich D | 16 | 77 1 | 11. | 110 |
| Cana | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | iture | 1.00 | auc 1- | Va | (1 hers | ung | 1011 |
| State Registrar | JAN 2 8 2000 | Busines | A. | back | e de la companya de | | | | |

16753493 SAURI, MICHAEL MD
BURLESON, CARSON
01/19/00 M 74 08/29/25
M/R # 0093032
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Please Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | | | Cert | tificat | e of De | eath | | Reg. No. | i U | J 4 0 8 |
|---|---|--------------------------------------|--|--------------------------------|-----------------------------------|------------------------|--|--|---|--------------------------------|----------------------|---|
| Physician | 1. Decedent's Nam | e (First, Middle, Las | t) | | | | | | 2. Date of De Month | Day | Year | 3. Time of De |
| /Medical Examiner | THELMA 4e Facility Neme (| ELIZ I not institution, give | ABETH street and number | | ROWN | | 4b. | City, Town, o | Janua Location of Deat | ry 27,20 | | 3:00P |
| | Civista | Medical C | enter | | | | La | a Plata | a | Char | les | |
| Funeral Director | 5. Social Security N 224-36- | 0721 | 9X □ M 2X F | Age (In yrs. I | last birthday) _ Yrs. | If Under Months | 1 Yeer | Under 24 Hr Hours Mir | 8. Date of Bi | rth ay, Year) | 9. Birthpli Count | ace (State or F ry) ginia |
| 1 | Usual Residence of | 10b. County | | 10c. City | , Town or Loc | ation | | | | | 110 | d. Inside City |
| be notified a | VA | Allegi | nany | C1 | ifton | , | | | | | | 1 TYes 2 |
| ust be n al Dir | 10e. Street and Nur 1014 Ma | in Stree | et | | | 101. Zip | 24422 | | | 10g. Citizen of 1 | | ay? |
| Examiner must Examiner must by Funeral | | ied 2 Married 4 Divorced | 12. Was Deceder Armed Forces 1 Yes 2 The Yes, Give Year or Dates | 7 (No | | /as Deced Yes, spec | | anic Origin? (Mexican, Pue Specify: | (Specify Yes or No erto Rican, etc.) | 14. Rac Bla Specif | ck, White, e | |
| ygiene. ner than 'naturi ri, the Medical. Completed | | 15. Decedent's Ed | de completed) | | 16a. Decede (Give k life. D | and of wo | al Occupation rk done duri se retired) | n ing most of w | orking | 16b. Kind of B | usiness/Ind | ustry |
| | Elementary/Second 11 | (First, Middle, Last) | College (1-4o | r 5+) | Food | Ser | | Mother's N | ame (First, Middle | Food | Ser | vice |
| E S E | | am Key | | | | | | | | | , | |
| To To | | ame/Relationship (7 | vne Print) | | 19h Mailing | Address | | | ssa Pet | | State 7in | Code) |
| 27 is | | ullock/I | | | | | | | ve Wald | | | |
| of the second | 20a. Method of Dis | | | | lace of Dispos emetery, cremi | | | | Date | 20c. Location | | |
| 10 10 | | ☐ Cremetion 3 ☐ 5 ☐ Other (Specify | | 8 | | | | meter | y2/3/00 | Clif+ | on F | orga I |
| Departs Imports any inju | 21. Signature of Fu | neral Service Licen | 500 | M0084 | Ä | Name and | RT-E | CHOLS | FUNERA A PLATA | L HOME | ,P.A. | |
| ysician Nedical aminer | Immediate Cause (disease or condition resulting in deeth) | | a. Cereb | ral V | ascular | Acc | ident | | | H | 1 | Interval Betwe Onset and Dec |
| in and rial-transit Examiner | Sequentially list co | nditions, | ьтуре | | abetes | ence of): | | | | | | |
| as the burners of Aedical | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I | | d | Due to (or | as a consequ | ence of): | | | | | 1 | |
| of for use | Part II. Other signif | icant conditions co | ntributing to death | but not resu | illing in the unc | derlying c | ausa divan i | in Pert I | 23b. Did | tobacco use co | entribute to | the cause of |
| ed by the attendir deteched for use / Physician/h | Tartii. Ostor algini | ount conditions co | THIRDUING TO GOLDT | DOI NOT 1630 | many mi the time | oony ang c | ausa givei i | arr on tr | | Yes 2□ No | 3 Prob | . / |
| page 2 should be del | | | | | | | | | 24a. Was | s an autopsy ormed? | con | ore autopsy find ilable prior to appletion of cau leath? |
| te has page 2 | | | | | | | | | 10 | Yes 20 No | 10 | Yes 20 No |
| s certificate hadirector, page | 25. Was case refer | red to medical | | | | | 2 | 6. Place of D | eath (Check only | one) | | |
| | 1 2 Yes 2□ | No | Hospital: 1 ☐ Inpa | tient 2121 | ER/Outpatient | 3 DC | Other: | 4 Nursing | Home 5 ☐ Res | idence 6 🗆 Ott | her (Specify | ') |
| After the funeration: | 27. Manner of Deat 1 ☑ Natural 2 ☐ Accident | n 5 ☐ Pending Investigation | 28a. Dete of In (Month, E | jury lay Year) | 28b. Time of Injury | M 2 | 28c. Injury et Work? 1 ☐ Yes | s 2 No | 28d. Describe | how injury occur | rred | |
| Mining a nous and open. To the Funeral Director: After to completely filled in by the funeral Medical Certification: | 3 Suicide 4 Homicide | 6 Could not be determined | 289. Pieca of I | njury - At ho etc. (Specify | me, farm, stre | et, factor | y, office | | | (Street and Numi wn, State) | ber or Rura | Route Numbe |
| Per Funer pletely fill edical | 29a. Certifier (Check only one) | 1☐ Certifying Phy 2☑ Medical Exam | | of examinet | | | | | | | | |
| Me Me | 29b. Signature and | title of certifier | | | | 290 | c. License n | umber | | 29d. Date signe | ed (Month, L | Day, Year) |
| | | | | | | | | | | , 1 | 1 - | |
| | UK | he p | 1. 7 Ay | en | | | -50883 | 3 | | 1/28 | 100 | |
| | 30. Name and address | | | | | rint) S | t Mai | ry to H | ospital | Dont of | - | |



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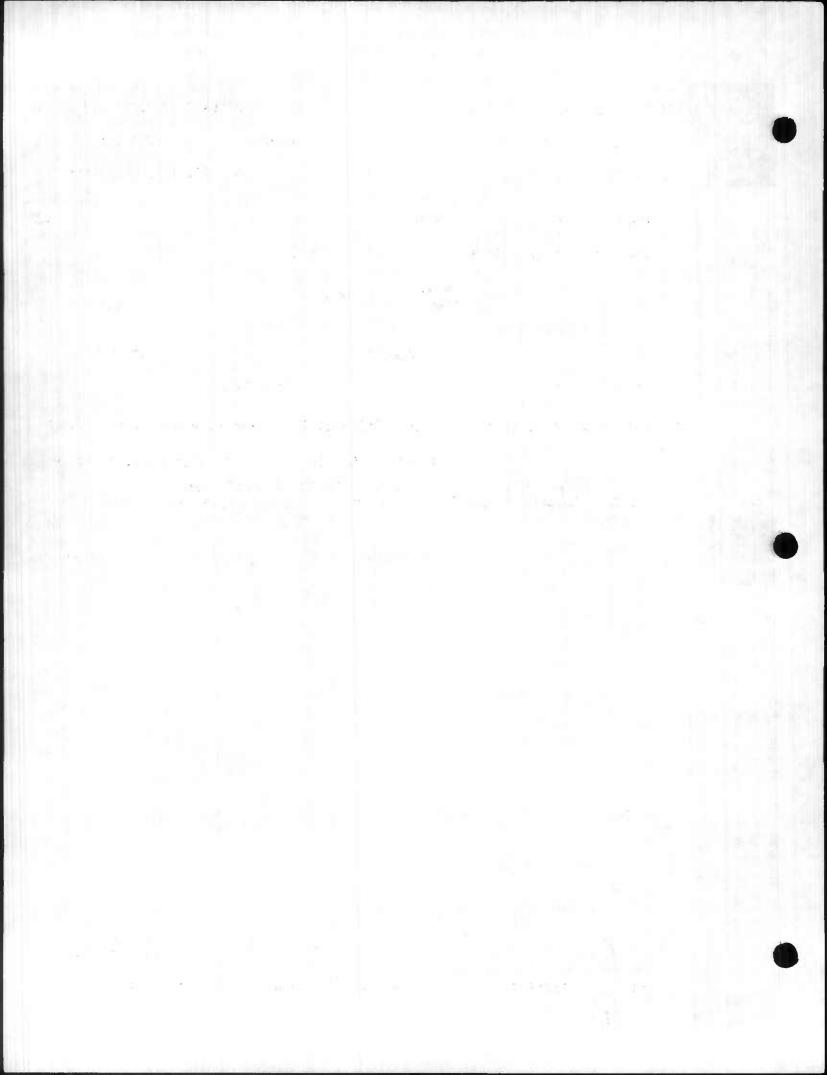
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28, JANUARY 2000 1:15 PM CARL BARNES **EDMOND** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner CHARLES 4064 OLD WASHINGTON ROAD WALDORF 9. Birthplaca (Stata or Foreign Country) Mary land 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) **Funeral** 100 M 2□ F Yrs 169-24-9134 77 Director Usual Residence of Decedent with the Merylend 10a. Stata 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 Yes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Permit. Peges 1 and 2 should be filed within 72 hours effer death with Engagement of Health and Mental Hygiene.

Important: If Hem 27 is marked other than """

any injury or other traument. "natural", or itema 23s or 20602 U.S.A. 4064 Old Washington Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 11. Marital Status 1 X Yes 2 No 1939 -If Yas, Giva Year or Datas: 1946 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Jeweler Self employed 8 17. Fathar'a Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Burton Barnes Clara Creek 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda M. Antolini/Sister 1612 Ridge Road, Jeannette, Pennsylvania 15644 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1X Burlal 2 Cramation 3 Removal from State Twin Valley Cemetery 02-02-2000 Delmont, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC. JOHN P. M01164 KNISLEY P.O.BOX 156 WALDORF, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physiclan** /Medical Immediate Ceuse (Final disease or condition resulting in death) NOV 99 Examiner Due to (or (s)e consequence of): Unsu Physician/Medical Examin that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) P.O. Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequence of): 80 nse Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of causa of death? We page 2 1 ☐ Yes 2 No certificate 1 ☐ Yas 2 ☐ No Physician: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? After 5 Pending investigation or Attending 1 Natural death. 1 TYes 2 No 2 ☐ Accident after deatl 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45737 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMALADEVI GURUSAMY, MD, 6 POST OFFICE ROAD, WALDORF, MARYLAND 20602 31. Data filad (Month, Day, Year) 32. Registrar's Signature Lycar FEB 01 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | Decedant's Name (First, Middla, Lasi | orate of maryland | | ificate of | | , , | g. No. | 04083 - |
|---------------------|--|---|---|---|---|--|--|-------------------------------------|--|
| | Physician | | | | | | Month January | Day Yes | ar . |
| | /Medical | JONNIE M. BOBO 4a Facility Nama (If not institution, give | | _ | | 4b. City, Town, or Lo | | 4c. County of D | |
| | Examiner | 820 Berkshire | | | | Hyattsvill | | | George's |
| | Funeral Director | 3/8-/0-2648 | 7. Age (In yrs. I | last birthday) Yrs. | If Under 1 Yaar Months Days | | 8. Date of Birth (Month, Day, June 12, | Year) 9.1 | Birthplace (State or Foreign Country) Shington, D.C. |
| | B | Usual Rasidence of Dacedent 10a. Stata 10b. County | 10c. City | v. Town or Loca | ation | | | | 10d. Inside City Limits |
| | Mary mer sho filed a | | rge's Hyat | tsville | | | | | 1 X Yas 2 □ No |
| | ith with the Maryla 23a or 28a-f show ust be notified at ral Director | 10a. Street and Number 820 Berkshire Drive | | | 10f. Zip Code 20783 | 3 | 10 | og. Citizen of What United S | |
| 020 | urs after des af, or flams Examiner m by Fune | 11. Merital Status 1 Nevar Married 2 X Married 3 Widowed 4 Divorced | 12. Was Decedant Ever in U,s Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: | | as Decedent of H Yas, apecify Cub. | lispanic Origin? (Spr an, Mexican, Puerto Specify: | ecify Yas or No- Rican, etc.) | Black, W Specify: | merican Indien, hita, atc. Afro- American |
| Maryland 21215-0020 | ed within 72 ho ygjern. we than "naturn it, the Medical. Completed | 15. Decedent's Edu (Specify only highest grad | | (Giva ki lifa. Do | nt's Usual Occup nd of work done O NOT use retire tered Nu | during most of work d) | ing | 6b. Kind of Busina | ss/industry |
| 9 | | 17. Father's Nama (First, Middla, Last) | 7 7 7 7 | 1.05-0 | 00200 110 | 18. Mother's Name | (First, Middle, N | | 110 |
| lan | hand of the sand o | Clarence J. Young | | | | Alice Ri | vers | | |
| lany | and Warner | 19a. Informant's Name/Ralationship (T) | ype, Print) | 19b. Mailing | Addrass (Street | and Number or Run | al Routa Number, | City or Town, State | e, Zip Code) |
| | and | James Chester Bob | | 1 | | Dr. Hyat | | | |
| Baltimore, | Pages 1 hart at lot h ant: if he ury or of | 20a. Mathod of Disposition 1 🔀 Buriel 2 Cremation 3 F 4 Donation 5 Other (Specify) | Hemoval from Stata | | tion (Nama of atory or other pla 1n Cemet | 1 | | 80c. Location - City Brentwoo | d, Maryland |
| Ball | Departition of the popular pop | 21. Signature of Funeral Service | A fresion | | Nama end Addre | ess of Facility St | | uneral Hosh. D.C. | |
| | | 23a. Pan 1. Entar tha disaase or composhook, or haart failura. List only o | licetions that caused the death na causa on each line. | . Do not entar | tha moda of dyin | ng, such as cardiac | or respiratory arre | est, | Approximate Interval Between Onset and Death |
| 4 | Physician /Medical Examiner | Immediata Causa (Final disaasa or condition rasulting in death) | a. Lung (| r as a conseque | ence of): | non-su | rall | cell | Crisel and Death |
| 90, | ifficate be executed giphysician and as the bunal-transit | Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disease or Injury | bDua to (or | r as a conseque | enca of): | | | | |
| | certificate be nding physicia use as the bu n/Medical | rasuiting in death) Last | Due to (or | es e conseque | ence of): | | | | |
| m | death cert e attendin ed for use sician/N | Part II. Other aignificant conditions con | ntributing to death but not resu | uition in the und | lerlying causa nit | ven in Part I | 23b. Did to | bacco use contrib | ute to the cause of death? |
| P.0 | the sch | | mostling to could be not read | ating in the dire | onying babba gr | | 100% | / | Probably 4 Unknown |
| Vital Records, | aw requisite been 2 should | | | | | | 24a. Was ar perform | | b. Were autopsy findings available prior to completion of cause of death? |
| œ | The la page page | | | | | | 1 ☐ Ya | s 2 No | 1 Yes 2 No |
| /ita | ysician: The is certificate director, pag | 25. Was casa referred to medical axaminer? | | | | 26. Place of Deat | h (Check only on | 9) | |
| ō | this aidi | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | Hospital: 1 ☐ Inpatiant 2 ☐ I 28a. Data of Injury (Month, Day Year) | ER/Outpatient 28b. Tima of Injury | 28c. Inju | 4 LJ Nursing Ho | | nce 6 Other (S w injury occurred | Specify) |
| 5 | To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After completely filled in by the funera Medical Certification: | 2 Accident Invastigation 3 Suicide 6 Could not be 4 Homloida datarmined | 28a. Placa of Injury - At ho building, etc. (Specify | oma, farm, stree | | | 28f. Location (Sti City or Town | | Rural Routa Number, |
| | Hospi 4 hou Funer tely fill | | sician: To the best of my know iner: On the basis of examinati | | | | | | |
| | within 2 To the comple | 29b. Signetura and titla of certifier | e Other | - | 29c. Licens | 1/ 0 | 25 | od. Data signed (Mi | onth, Day, Year) |
| | (20) | 30. Nama and addrass of person who con Susan Bruns | omplated causa of death (Itam) | 23a) (Type, Pi adenSi | burg t | ld Colm | arMa | enor, X | 1) 20722 |
| | State Registrar | 31. Data filed (Month, Dey, Year) JAN 2 7 2000 | 32. Registrar's Signat | d. | frak | / | | | |

Destro Brown

34.4 2 # 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 01,084 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Allie 19, 2000 January Pin /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 8. Data of Birth (Month, Day, Year) August 13 1913 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 N. C. **Funeral** 10 M 20 F Days Months Hours N.C. 579-09-9601 86 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits a how Md. Prince George's Brandywine 1X Yas 2 No Funeral Director 284-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Herna 23a 13403 Cherry Tree Crossing Rd. 20613 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effar of Department of Health and Mental Hygiena. Important: If Ham 27 ia marked other than "natural", or head any injury or other treumatic ayant issues. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Presser Dry Cleaning 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 8 James Barber Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Essie Orange / Daughter 13403 Cherry Tree Crossing Rd. Brandywine, Md. 20613 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition

12 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Harmony Memorial Cemetery1-25-00 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC mitions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, in cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediate Causa (Final Probable CVA hours. disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Jears-The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Caratid Artery Disease ears P.O. Box 68760, been signed by the ettending physician should be deteched for use as the burie Physician/Medical Due to (or as a consequence of): RAS Dinketes mellitus Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à Be Completed 24a. Was an autopsy performed? Ware autopsy tindings available prior to completion of cause of death? hes 1 Yes 2 No 1 1 Yes 2 No certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was casa refarred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 4 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 (Naturat 1 Yas 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide edical ft Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture and littly of centile 29c. License number 29d. Data signed (Month, Day, Year) 126352 no completed cause of death (Item, 23a) (Type, Print) O.L. HAYR 9/31/15ca Dawny Rd 31. Date tiled (Month, Day, Year)

JAN 2 7 2000 32. Registrar's Signature State

Registrar

MOOS VMAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Year Month **Physician** Brooks 12:20 20 2000 Jan /Medical Magnolia 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Roac-Nursing Home

7. Age (In yrs. last birthday) Vit Under 1 Year Lanham H Under 24 Hrs. 8 Good uck 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) Sex 1XM 2□ F **Funeral** 097 Months Days Hours 58 Yrs. mary Director Jan 15 1899 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Washington, 28a-f 10e. Street and Number 10g. Citizen of What Country? ò N.W USA 8 20011 Funeral Wes Decedent Ever in U,S. Armed Forces? 1 Yes 20 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black Maryland 21215-0020 A 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Statistician 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Not Available Not Available 19a. Informant's Name/Reletionship (Type, Plint) DAUGHTEC 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elgine Leroy, NY East Booten Ave. mportant: If item 27 Baltimore, 20a. Method of Disposition

1 ABuriel 2 Cremation 3 Removal from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 6 □ Donation 5 □ Other (Specify) Lincoln mem Cenc 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Rhines Co. 3030-12th. St, NE Wash DC 20017 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Atheroscleolic Cardisvascular Disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the Due to (or as e consequence of) USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 20 No 1 Yas 2 No certificate Division of Vital 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) and manner stated. (Check only one) within 2. To the F the 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 039550 -20-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forbes Blod Lahham, And 20706 31. Date filed (Month, Day, Year)
JAN 2 7 2000 4850 May 11. mo Cr

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

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| Physician Medical Examiner Physician Physician | Maryland |
| Physician Medical Examiner Physician Physician | |
| Physician (Medical Examiner) 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. 25b. Due to (or as a consequence of): 25c. Sequentially list conditions, liany, lacding to immediate Cause (pissase or condition resulting in death) 25c. Due to (or as a consequence of): 25c. Due to (or as a con | 0 20701 |
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| Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): d | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Rheumatic Heart Disease 1 Yes 2 No 3 Protection | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Rheumatic Heart Disease 1 Yes 2 No 3 Protection | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Rheumatic Heart Disease 1 Yes 2 No 3 Protection | |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Rheumatic Heart Disease 1 Yes 2 No 3 Protection | |
| Status Post-Op Mitral Valve Replacement 1984 24e. Wes en eutopsy performed? 24b. Wes en eutopsy performed? 1 Yes 2 No 1 25. Wes case referred to medical axaminer? 1 Yes 2 No No No 27. Manner of Death No No No 28a. Date of Injury No No No 28b. Time of No No No 28c. Place of Deeth (Check only one) 27. Manner of Death No No No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Run Chy or Town, Stefe) | the cause of death? |
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| Solicide Solicide Suicide Sui | |
| A Homicide building, etc. (Specify) City or Town, Stete) | I Route Number |
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| | |
| 29a. Certifier 29a. Certifier 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a second of the cause of | ated. the ceuse(s) |
| and manner stephyl. | (110 00000(0) |
| and manner stephol. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, | Day, Year) |
| 25808 1/23/0 | (7) |
| | |
| 30. Name and address of person who completed use of death (Item 23a) (Type, Print) | 2 5006 |
| Herman B. Segal, M.D. 10313 Georgia Avenue #307, Silver Spring, MD 2090 | 2-3006 |
| State Registrar 31. Dete filed (Aporth, Pay Year) AN 2 7 2000 32. Registrar's Signature | |

Grann is fireway

JAN 2 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| ysiciar Medica amine erai | | | | | Department of Certificate of | of Death | Reg. | No. | 0 0408 |
|------------------------------------|---|--|---|---|---|--|--|----------------|--|
| dica ine | | ne (First, Middle, La | ist) | | | | Dete of Death Month | Day | 3. Time of De |
| | Thomas | | Cooper | -1 | | | | 20, 20 | |
| | 100000000000000000000000000000000000000 | | e street and numbe | | | 4b. City, Town, or Loc | | 4c. County | |
| | 5. Social Security N | | tist Hosp | Age (In yrs. last b | irthday) If Under 1 Ye | | 8. Date of Birth | Montgo | 9. Birthplace (State or F Country) |
| | 224-38-20 Usual Residence o | 083 | 1 ⊠ M 2□ F | 66 | Yrs. Months De | ys Hours Min. | (Month, Day, Ye | | Richmond, \ |
| - Annual | 10e. State Maryland | 10b. County Montgon | nery | | m or Location r Spring | | | | 10d. Inside City L 1 X Yes 2 |
| Directo | 10e. Street end Nu | mber | | | 10f. Zip Cod | e | 10g. | Citizen of W | /hat Country? |
| | | nder Lane | | | | 20901 | | U.S. | Α. |
| Firedral | 11. Maritel Status | | 12. Wes Deceder Armed Forces | 5? | Was Decedent of If Yes, specify C | of Hispenic Origin? (Spec Juban, Mexican, Puerto F | cify Yes or No- lican, etc.) | | - American Indien, k, White, etc. |
| 3 | 3 ☐ Widowed | led 2⊠ Married 4 □ Divorced | I by Yes 2 If Yes, Give Year or Dates | 3/52 - ≈ 3/56 | 1□ Yes 2☐ | No Specify: | | Specify | Black |
| 4000 | (Spec | 15. Decedent's Edify only highest gra | ducation ade completed) | 160 | B. Decedent's Usual Oc (Give kind of work do | cupetion ne during most of workin tired) | g 16b. | Kind of Bu | siness/Industry |
| Completed | Elementery/Seco | ondary (0-12) | College (1-4o | (5+) | | tired) | | | |
| 00 | 17. Father's Name | (First, Middle, Last | 2 yr: | S. | Engineer | 18. Mother's Name | | | epartment |
| Da C | | B. Cooper | | | | Marie God | | en Sumann | 0) |
| F | | ame/Reletionship (| | 19 | b. Mailing Address (Stre | eet and Number or Rural | | v or Town | State Zin Code) |
| | | ooper - V | ,, , | | | r Lane, Silv | | | |
| | 20a. Method of Disp | position | | 20b. Place | of Disposition (Name of ery, cremetory or other p | and the same of th | | | City or Town, State |
| | 1 Burial 2 | ☐ Cremation 3 ☐ 5 ☐ Other (Specify | Removal from Stat | ы | ico Nationa | | -26-00 Tr | iana1 | e, Virginia |
| | 21. Signature of Fu | | | Quant | | | | | e, viiginia |
| L | 1 1- | D in | 0 00 | | | dress of Facility 11's Funera. | | | |
| | 230 Conti Enter | P. III | rispall | od the death. De | 4217 91 | th Street N | .W. Washi | ngton | |
| ı | shock, or hee | rt feilure. List only | one ceuse on each | line. | not enter the mode or t | dying, such as cerdiac or | respiretory arrest, | | Approximate Interval Betwee Onset and De |
| | Immediate Cause (| (Finel | | | | / | | | 1 |
| | disease or condition resulting in deeth) | in | a. 0411 | COPAL | Epi | Sode- | | | hour |
| Jor | | | m. | Dyfe to (or es e | consequence of): | sode | -11 | , , | |
| Framiner | Composite live list on | aditions C | b. 111A30 | DUA TO LOVAS A | MYOCA | ROLAL J | STARCT. | 00 | |
| | | nmediate eriving | 0.71 | _ | (1 | | | | |
| 63 | that Initiated events | Injury | c. 14 11/1 E | | cheros, | 5 | - | | |
| And | resulting in death) i | Last | | | | | | | |
| N/UE | | | d | - | | | | | |
| Physician/Med | Part II. Other signif | lcant conditions of | ontributing to deeth | but not resulting | in the underlying cause | given in Pert I. | 23b. Did tobac | co use con | tribute to the cause of |
| Shv | | , , , | // | | | | 1 ☐ Yes | 2 No | 3 Probably 4 ☐ Ur |
| by | . 11/8do | rAte. | Hype | 1/ENO | 3100 | | | | |
| | | | | | | | 24e. Wes en eu | topsy | 24b. Were sutopsy fine avelleble prior to |
| Completed | | - | | | | | | | completion of cau of death? |
| mo | | | | | | | 1 ☐ Yes | 22 No | 1 ☐ Yes 2 ☐ N |
| | 25. Wes case refer | red to medical | | | | 26. Plece of Death | (Check only one) | | |
| × | examiner? | No | Hospital: | tient 2 NER/O | utpatient 3 DOA | Other | e 5 Residence | 6 ∏Othe | or (Specify) |
| To Be | | | 28a. Date of In (Month, D | jury 28b. | Time of 28c. In | | 8d. Describe how In | | |
| n: To Be | 1 Natural | 5 Pending Investigation | | ay rour) | | ☐ Yes 2☐No | | | |
| 10 | 2 🗋 Accident | 6 Could not b | 289. PIECE OF II | njury - At home, f | arm, street, fectory, office | ce 21 | Bf. Location (Street City or Town, St | and Numberate) | er or Rural Route Number |
| 10 | 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide | determined | | ,, | | | | | |
| Certification: To | | determined | velclan: To the has | t of my knowledg | e, death occurred et the | time, dete and place, ar | nd due to the cause | (s) and mar | nner as stated. |
| edicai Certification: To | 29a. Certifier (Check only one) | determined 1 Certifying Ph 2 Medical Exam | velclan: To the has | t of my knowledg | nd/or Investigetion, In m | y opinion, deeth occurred | d at the time, date a | and place, e | and due to the cause(s) |
| Certification: To | 29a. Certifier (Check only one) 29b. Signeture end | determined 1 P Certifying Ph 2 Medical Exam | ysician: To the bes | t of my knowledg of examination a stated. | nd/or Investigation, In m | e time, dete and place, ar y opinion, deeth occurred ense number | d at the time, date a | and place, e | (Month, Day, Year) |

Registrar **DHMH 16 Rev 6/95**

State

111 Penn Street, Baltimore, Maryland 21201

30. Name and address operson who completed cause of death (Item 23a) (Type, Print) M.D.

32. Registrar's Signeture

JACK M. TITUS

31. Date filed (Month JAN 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Output

Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** 438 2000 JANUARY 26 James Douglas Carter /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner BRENTWOOD PRINCE GEORGES SHEPHERD STREET If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 6 Sex Birthpiece (State or Foreign Country) **Funeral** Days 100 M 2□ F Months Director 283-32-5236 62 Jan. 5,1938Dayton,Ohio Usuel Residence of Decedent the Maryland 10c City Town or Location 10a Stete 10b. County 10d. fnside City Limits I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Yes 2 No Maryland Prince George Directo Brentwood (Cottage City) 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 4115 Shepherd St. 20722 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: SpecifiAfrican Amer þ 3 Widowed 4 N Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Correctional Officer Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be h and Mental h Joshua Carter Minnie Regulus 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health a If item 27 is or other the Beverly Carter-John(Daug.) 4915 56th Ave., (Hyattsville, Md. 20781) Saitimore, 20b. Place of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other piece) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Ft. Lincoln Cemetery 2/3/00 Brentwood, Md. 5 ☐ Other (Specify) 22. Name end Address of Fecility
Stewart Funeral Home, Inc. 21. Signature of Funeral Service Light Benning Rd., N.E. (Wash., D.C. 20019) 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel · APTERIOSCLEPOTIC CARPIOVASCULAR PISEASE diseese or condition resulting in death) Examiner Examiner certificate be executed and bunal-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician P.O. Box 68760 Physician/Medical the Due to (or es e consequence of) 60 use Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveileble prior to competition of cause 24e. Was en eutopsy Completed peen page 2 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No Division of Vital Attending Physician: 25. Was cese referred to medice Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
njury at 28d. Describe how injury occurred 20 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of After 1 Neturel 2 Accident 5 Pending Investigation il or Attending s after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide To the Hospital o within 24 hours af To the Funeral Di completely lilled in edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es ateted.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signato 29c. License number 27 2006 ted ceuse of death (Item 23a) (Type, Print) 3001 HOSPITAL M7 VRIVE CHEVERLY

32 Registrer's Signature

State Registrar Transfer and the second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:10 a.m. Mary Kellogg Crecco 26, 2000 January /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Genesis ElderCare Riverdale Prince George's If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 027-28-0920 1 □ M 2 K) F Feb. 28, 1930 North Dakota Director Usual Residence of Decedent the Maryland 10a. Sfele 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic avent, one Medical Examiner must be notified as Maryland Prince George's College Park 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5942 Westchester Park Drive 20740 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hyglene. Infortant: if item Z7 Is marked other than "natural", or the limportant: if item Z7 Is marked other than "natural", or the any Injury or other traumatic avent, or Health Examine and Injury or other traumatic avent, or Health Examine Dices. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Non-Profit Elementery/Secondary (0-12) College (1-4or 5+) Financial Administrator Environmental Group 6 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lucille Reasner Charles Kellogg 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Francis Crecco - Husband 5942 Westchester Park Drive, College Park, MD 20740 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/00 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
Gasch's Funeral Home 21. Signature of Funerel Service Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death Physician /Medical Immediate Cause (Final Me tastatic Adenocananoma disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 20.00 Box 68760, Physician/Medical 8 Due to (or as a consequence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown ement'a Records. p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 monio The law 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA H 28a. Dete of Injury (Month, Day Year) Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Athar Division Attending 1 Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hoopital or Attendi 24 hours after death Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 7 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

A. DEVORE, MD 32. Registrar's Signature

DHMH 16 Rev 6/95

29c. License number

4203 QUEENSBURY Rd Hyattsville MD 20781

29d. Date signed (Month, Dey, Year)

JANUARY 26,2000

JAN 2 7 2000

in and

State of Maryland / Department of Health and Mental Hygiene

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| sician | 1. Decedent's Name (First, M | 42 4 44 4 | | | | | | | | | | | | | |
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| sician | 1. Doodoont o traino (rirot, ir | fiddle, Las | st) | | | | | | | | | | V | 3. Tim | of Death |
| | Elizabeth Eld | lora | Camphe | 11 | | | | | | | | | | 10. | 15 . |
| edical | 4a Facility Name (If not instit | | | | | | | 4b. City, To | own, or Lo | | | | | 1.0 | 15 8. |
| miner | 3533 Otis Str | | A BARBON COMMISSION | | | | | Mr. T | | | | | | | |
| , | 5. Social Security Number | 6. Se | | 7 Ann //n | foot blothule | a) H Lind | or 1 Vee | | | er | P | rin | | | |
| ral | | | M 25F | Ab. City, Town, or Location of Death Ac. County | | Count | try) | te or r-oreigi | | | | | | | |
| tor | 537-20-7049 | | X | /3 | 113. | | | | | March | of Death Dey Year are ary 20 2000 10: Prince George Selection of Death Prince George Selection (Country) 10: 10g. Citizen of What Country? 10g. Citizen of What Country? 11g. S. A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Restaurant ddle, Maiden Surneme) 1cCurry Sumber, City or Town, State, Zip Code) inier, Maryland 207 20c. Location - City or Town, State 200 Brentwood, Maryl. A. Syattsville, MD. 207 Approximately Approximately Selection of Sele | ee | | | |
| | Usual Residence of Decedent 10a. State 10b. Con | | | 100 0 | ty Town or I | contion | | | | | | Prince George's 9. Birthplace (State or formetry) 1926 Tennessee 10d. Inside City 11 Yes 2 Sitizen of What Country? 1. S. A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry Restaurant In Sumame) Ty 1. Or Town, State, Zip Code Maryland 20712 Location - City or Town, State entwood, Marylan | Ch. Limite | | |
| _ | 100.00 | urity | | 100.0 | ny, rown or L | OCALIOIT | | | | | | | | | |
| recto | Maryland Pri | nce (| George' | s M | t. Rain | nier | | | | | 1td Yes 2L | | | | es 2LING |
| Director | 10e. Street and Number | | | | | 10f. Z | ip Code | | | | 10g. Citiz | zen of W | hat Count | try? | |
| | 3533 Otis St | reat | | | | 20 | 7712 | | | | 71 | C A | | | |
| - Je | 11. Marital Status | .1000 | 12. Was Dec | edent Ever in L | J.S. 13. | Was Dec | edent of | Hispanic Or | iain? (Sp | ecify Yes or N | | O . A | - America | en Indier | 1, |
| Funeral | 1 Never Merried 2 📉 | Married | | | | If Yes, sp | ecify Cul | oan, Mexice | n, Puerto | Rican, etc.) | | Blec | k, White, e | etc. | |
| by | 3 ☐ Widowed 4 ☐ Divo | | If Yes, Gi | VO OV | | 1 🗆 Yes | 2 X No | Specify. | | | | Specify. | Whit | e | |
| | | | | 9(95: | | | | | | | 1 | | | | |
| ete | 15. Dece (Specify only hi | dent's Ed | | | (Give | e kind of v | vork done | during mos | st of work | ring | 16b. Kir | nd of Bu | siness/Ind | lustry | |
| Completed | Elementary/Secondary (0-1 | | | 1-4or 5+) | life. | DO NOT | use retire | 90) | | | | | | | |
| 0 | 12 | | | | Wai | tress | 5 | | | | R | esta | auran | t | |
| Be | 17. Father's Name (First, Mid | dle, Last) | | | | | | 18. Moth | er's Nam | e (First, Middl | le, Maiden | Sumem | e) | | |
| 0 | Burl James Ra | ines | | | | | | Eula | Sue | 11a Mc | Curry | | | | |
| F | 19a. Informant's Name/Relet | | Type Print) | | 19h Meil | ling Addre | ss (Stron | | | | | _ | State Zin | Codel | |
| | | | | | | | | | | | | | | | |
| | Bruce W. Cam | ppell | L - Spo | | 3533 | 3 Oti | s St | reet, | Mou | | | | | | |
| | 20e. Method of Disposition 1 X Burlal 2 ☐ Cremate | ion a 🗆 | Removal from | | cemetery, cre | ematory o | ame or r other pla | ice) | i | Date | 20c. Lo | cation - | City or To | wn, State | • |
| suce. | 4 Donation 5 Othe | | | | rt Lir | ncoln | Cem | etery | 1, | /24/2000 | Bren | itwo | od. M | larv. | land |
| Duce | 21. Signature of Funeral Sen | vice Licen | see | | 1 2 | 2. Name | and Addr | ess of Facil | | | 1 | | | | |
| | NAI | A.A. | _ 1 | N | G | asch' | s Fu | ineral | Hom | e. P.A | | | | | |
| | laced | ell | es. | INDO | | | | | | | | i116 | MD. | _ 20 | 781 |
| | 23a. Part1. Enter the disees shock, or heart feilure. | List only | olicetions that o | eused the dea | th. Do not er | nter the m | ode of dy | ing, such as | cerdiac | or respiratory | errest, | | | Approxi Interval | nete Between |
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| al | Immediate Cause (Final | | | | | | | | | | | | | | |
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| | disease or condition resulting in deeth) | | a. Pr | | | | A). | - 3 | | d f | | | | | |
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Kermit Shelton Canada

State of Maryland / Department of Health and Mental Hygi

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| | 1. Decedent's | Name (First, Middle, L | .ast) | | | | - | 2. Date of D | | Maria | 3. Time of Death |
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| hysician /Medical | Kerm | it Shelton | Canada | | | | | Janua Janua | Day | 2000 | 10:50 A.M. |
| /wedical Examiner | 4a Facility Na | me (If not institution, g | ive street end number |) | | | 4b. City, Town, o | or Location of Dea | | | 10.00 11.11 |
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| ineral | 5. Social Secur | | | ge (In yrs. last b | Months | r 1 Year Days | | | | | aca (Stete or Foreign try) |
| rector | 579-76 | | XXM 2□F | 44 | Yrs. | | | Dec.5, | 1955 | | ,D.C. |
| | Usual Residen | ce of Decedent | | 10c. City. Toy | wn or Location | | | | | 10 | Od. Inside City Limits |
| edal or | Md. | Prince G | Georges | | r Marlbo | oro | | | | | Yos 2□No |
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| mant 3 | 11. Marital Sta | | | t Ever in U.S. | 13. Was Dece | | | (Specify Yes or N | | e - America | an Indian, |
| formal formal funer | | Married 2 Namied | 12. Was Decedent Armed Forces 1 Yes 2 | | If Yes, spe | city Cub | an, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | Blad | ck, White, e | |
| by B | | red 4 Divorced | If Yes, Give Year or Dates: | | 1□ Yes | 2 No | Specify: | | Specify | Bla | ack |
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| t, the Medical. | | Specify only highest g Secondary (0-12) | College (1-4or | 5+) | Give kind of we life. DO NOT | ork done use retire | during most of v | vorking | | | |
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| a other sweat | 17. Father's Na | ame (First, Middle, Las | st) | | | | 18. Mother's N | lame (First, Middle | e, Meiden Sumen | ne) | |
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| and a | | t's Name/Retationship | | 19 | _ | | | Rurel Route Numi | - | | |
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| n item of the second | 20a. Method of | f Disposition | □ Bamouel from State | 20b. Place cemete | of Disposition (Ne | me of other ple | oca) | Date | 20c. Location - | City or To | wn, State |
| min of the | | ion 5 Other (Spec | | Harm | ony Memo | orial | l Park | 1-25 | Landov | er, Mo | i. |
| D A FEE | 21. Signature | of Funeral Service Lice | ensee | | 22. Name a | nd Addre | ess of Facility | hillip B | ell Fine | ral c | Service |
| 5 5 8 | 101 | ully 15 | ell | | 4902 | Star | | Rd., Temp | | | |
| | 22n Dortt Er | | | | | | | | | | |
| iician edical | shock, or | r heert feilum. List onl | mplications that cause ly one cause on each | ed the death. Do | not enter the mo | de of dyi | ing, such as card | liac or respiratory | | | Approximate Intervel Between Onset and Death |
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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OTTS DOUGLAS Jan 30 2000 CARPENTER 9:15 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-14-3093 89 December 6,1910 Maryland Usual Residence of Decedent 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Charles Nanjemoy 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12375 Riverside Road 20662 USA 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Shop Clerk State Hwy. Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Broadie Carpenter Edith Hancock 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2975 Baptist Church Rd. Nanjemoy, MD. 20662 Betty Mae Willett/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Nanjemoy Baptist Cem. 2/3/00 Nanjemoy, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death Atheroseleropic Cardiovascular Disease Immediete Cause (Final Mars disease or condition resulting in deeth) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

and

2

peed

certificate

requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

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MD

Funeral

Director

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altimore,

Director

Funeral

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Completed

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buriel-transit physician s the burial Physician/Medical signed b by Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💢 DOA 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homlcide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1 Natural 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 35

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

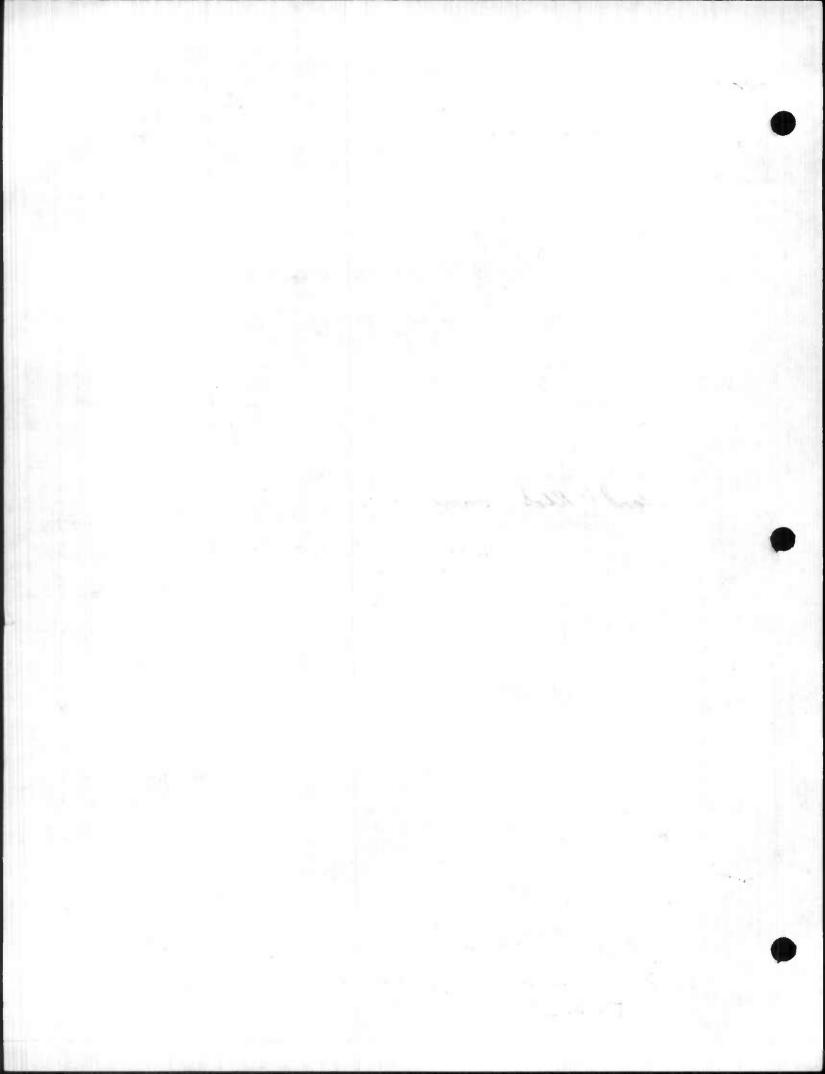
404 E.Charles Street LaPlata MD 20646 Charlene A Letchford MD

State Registrar

Medical

32. Registrar's Signature

D-46419



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1: Degedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Yeer **Physician** 40 2170 /Medical 4e Facility Nerge (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner If Under 1 MIT. Sex 1 M 2 □ F Birthplace (State or Foreign Country) Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys nknown Yes Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 00 Be Completed by Funeral Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Race - American Indian, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Merried 22 No 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) A N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) nowr 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rura mother erdee 21001 Unirle 20b. 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 Removal from 4 Donetion 5 Dother (Specify) | Spesal 21. Signature of Funerel Service Licensee 22. Name end Address of Facility N. Wolfe SA 600 eborah Evans Approximete Intervel Between Onset and Deeth 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. the mode of dying, such es cardiac or respiretory errest, **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medicat Lulmonar Examiner Due to (or as e consequence Physician/Medical Examiner rema as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Labor ANCA Due to (or es e consequence of): detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Š Be Completed by 24b. Wera autopsy findings available prior to completion of cause ot death? 24a. Wes en eutopsy performed? 1 Tes 2 1 No 1 🗆 Yes 213110 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2□ ER/Outpatient 3 DOA 27. Menner of Death Dete of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury et Work? After 5 Pending investigation 1 Matural Injury 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be asscuted 68760. Box P.O. Division of Vital Records.

Baltimore, Maryland 21215-0020

6 Could not be determined

4 Homicide

29e. Certifier

Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

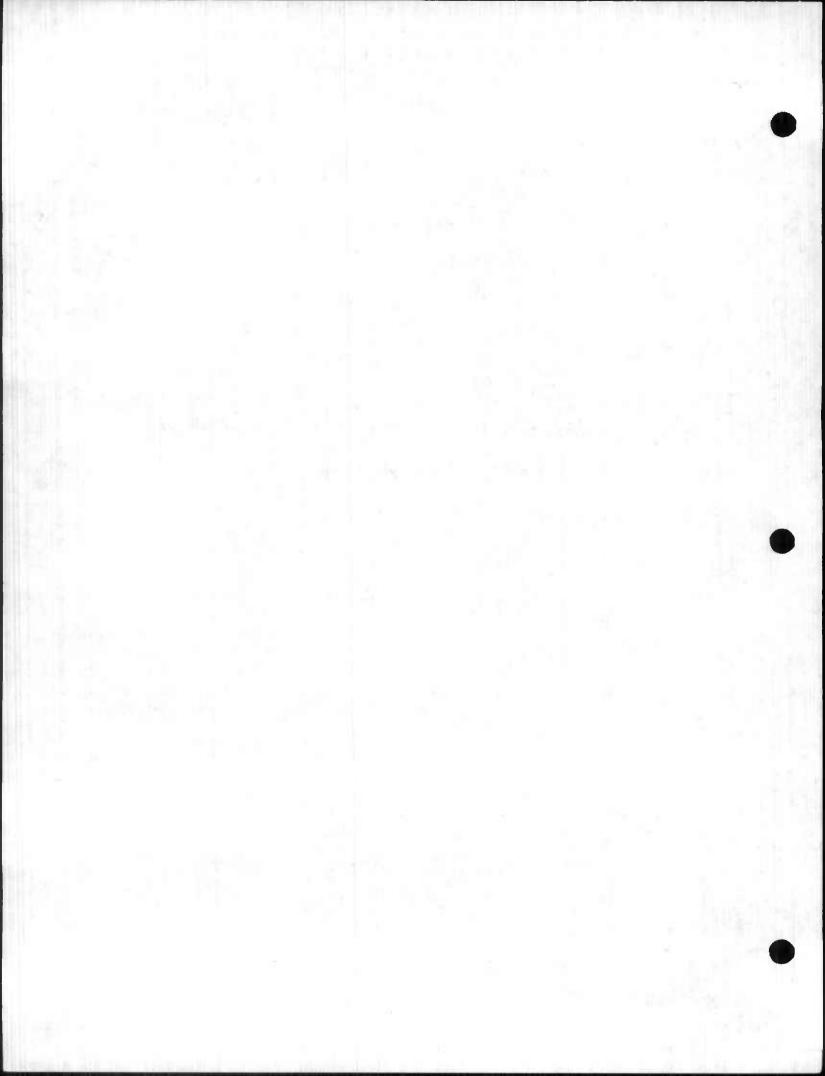
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

600 OFTAINE) Thin 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) Month **Physician** ornel 1601 Cottingham Februar 200C /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Hospita Baltimore Johns Hopkins 6. Sex 12 M 2□ F If Under 1 Year If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mir Unknown Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County City, Town or Location 10d. inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 234 5 2/2/3 10 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates: thema. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 12. Black, White, etc. 1 Never Married 2 Married 20 No 6 Saltimore, Maryland 21215-0020 Blace Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Be Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa retired); 16b. Kind of Business/Industry I Hygiene. o6ndary (0-12) College (5-4or 5+) other Mother's Neme (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) is marked of Knowr 19a. Informant's Name/Reletionship (Type, Priht) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, Department of Health ar Important: If item 27 is any injury or other trau md. 2/2/3 mother a 04/10 20b. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 🗆 Re 4 Donation 5 Other (Specify) 22. N 21. Signature of Funeral Service Licen DIte 600 23a. Part1. Enter the document or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** 6/ week Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence ot): Physician/Medical Examiner one dal The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last use as the burial-tran Due to (or as a consequenca ot) Box 68760. Due to for as a consequence of P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, þ 24a. Was an autopsy parformed? 24b. Were autopsy tindings available prior to completion of cause of death? page 2 should Medical Certification: To Be Completed After this certificate has 1 Tes 2 No 1 Yes 2 No or Attending Physician: 25. Was case reterred to medical axaminer? 26. Place of Death (Check only ona) Hospitat: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) 27. Menner of Death Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

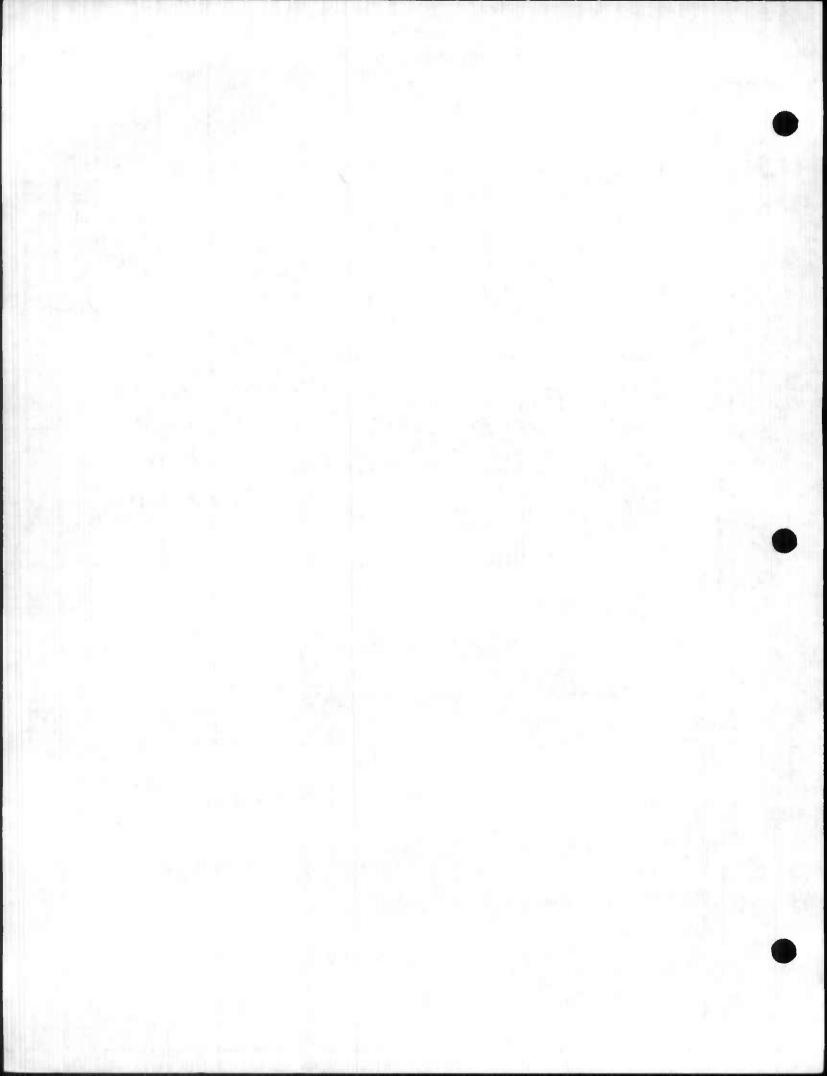
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier completaly (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 DRUAR4 30. Name and and of parson who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital

DHMH 16 Rev 6/95

State Registrar

31. Date tiled (Month, Day, Year)

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** FRANKLIN A. DIGGS JANUARY 25,2000 1:30am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CHERVERLY
If Under 24 Hrs. 8. D
Hours Min. PRINCE GEORGES 5. Sociel Security Number 6. Sex 1 → M 2 □ F If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 212-20-1767 74 Director MARCH 12,1925 NAYLOR, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnslde City Limita 10 1/9 7 is marked other than "naturel", or items 23s or 28s-f shot traumstic svent, the Marical Examination must be nutrised at YOYes 2 No Directo PRINCE GEORGES CAPITOL HEIGHTS the 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 20743 915 MENTOR AVE Funeral UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien 11. Meritei Stetus Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2K Merried 1 Yes 2 No BLACK Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10 CONSTRUCTION WORKER PRIVATE permit. Pages 1 end 2 should be file.
Department of Health and Mentei Hygi
Important: If them 27 is marked other any injury or other traum—
page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be IGNATIUS DIGGS BARBARA BROOKS 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) HILDA DIGGS / WIFE 915 MENTOR AVE CAPITOL HEIGHTS, MD 20743
Dete 20c. Location - City or Town, State 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Buriel 2 Cremetion 3 Removel from Stete RESURRECTION CEMETERY 1-31-00 CLINTON, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility
ALEXANDER S. POPE FUNERAL HOME 23a. Pert1. Enter the disease, or committations that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellura. List only one ceuse on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Approximete Intervei Between Onset and Deeth **Physician** /Medicai Immediete Ceuse (Finei ARDIOVAS CULAR disease or condition resulting in deeth) Examiner Due to (or es e consequence ot) Examiner ESPIRATORY AIWRE the death certificate be executed physician and the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) 36 HRS EREBRAL MORRILAGE Physician/Medical Due to (or es a consequence of): 98 USB 0 signed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No TENSION Division of Vital Records, pA 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed VIBRILI ATION completion of cause of death? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Wes cese referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ti⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Aftar 1 Neturel 2 Accident 5 Pending investigation after death. 1 Yes 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the I within 2 To the I complet 29b. Signature end title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) PRINCE GEORGE'S HOSPITAL GREEN MD -INDA D 31. Date tiled (Month, Dey, Year)

JAN 2 7 2000 32. Registrer's Signature State

Registrar

| | | • | Certificate | | R | eg. No. | 04097 |
|--|---|--|--|--|---|---|---|
| Physician | 1. Decedent's Name (First, Middle, Las Frances Anita Da | • | | | 2. Date of Deel Month | Day | Yeer 3. Time of Death |
| /Medical | 4a Fecility Neme (If not institution, give | | | 4b. City, Town, or t | January | 26, 20 4c. County | 000 6:20 p.m. |
| Examiner | Prince George's | | er | Cheverly | | | ce George's |
| Funeral Director | 5. Social Security Number 6. St 578–10–3186 | ex | last birthday) If Under 1 Y Yrs. Months D | ear If Under 24 Hrs. eys Hours Min. | 8. Dete of Birth (Month, Dey, March 1 | | Birthplece (State or Foreign Country) Virginia |
| p z | Usuel Residenca of Decedent 10e. State 10b. County | 10c Cit | y, Town or Location | | | | 10d. Inside City Limits |
| deeth with the Meryland rms 23a or 28a-f show Linust be notflied at | Maryland Prince G | | wie | | | | 1½ Yes 2□ No |
| 1284- north | 10e. Street and Number | | 10f. Zip Co | de | 1 | Og. Citizen of V | Vhat Country? |
| 3a ou | 7902 Orchard Park | Way | 20 | 0715 | | U.S.A. | |
| Fu Fa Fu | 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | S. 13. Was Decedent If Yes, specify 1 ☐ Yes 2 ☑ | of Hispanic Origin? (Si Cuban, Mexican, Puerti No Specify: | pecify Yes or No- o Rican, etc.) | 14. Race - American Indien, Black, White, etc. Specify: White | |
| 15-002 72 hours natural; ad call Evel | 15. Decedent's Ed (Specify only highest gre- | lucation | 16a. Decedent's Usual O | ccupation | king | 16b. Kind of Bu | usiness/Industry |
| 1 21215-002(led within 72 hours e bygiene. Nor than "natursi", on nt. fine Ved cal Exert Completed by | Elementery/Secondary (0-12) | College (1-4or 5+) | | one during most of wor atired) | Navy . | 011- | C |
| yland 212: ould be filed within Mentel Hygiene. merked other than metic event, the M | 17. Fether's Neme (First, Middle, Last) | 2 | Secretary | 18 Mother's Nam | ne (First, Middle, I | | Secretary |
| yland build be fil Mentel H Mentel H arked oth aric even | Jacob Tisinger | | | | Mae Hepn | | - |
| larylar 2 should be and Mente s marked summite e | 19a. Informent's Name/Reletionship (7 | Type, Print) | 19b. Mailing Address (St | | | | Stete, Zip Code) |
| C = 4 F | Anita D. Jackson | - Daughter | 7902 Orchar | d Park Way | , Bowie, | MD 207 | 15 |
| ges 1 en t of Heal if item 2 or other | 20a. Method of Disposition 1⊠ Burlel 2 ☐ Cremation 3 ☐ | Removel from State | leca of Disposition (Neme cametery, cremetory or other | plece) | | | City or Town, State |
| | 4 ☐ Donetion 5 ☐ Other (Specify | Arl | ington Natio | | 2/03/00 | Arlingt | on, Virginia |
| Baitim | 21. Signature of Funeral Service Licen | see A - A | | ddress of Fecility Funeral Ho | me | | |
| C8760, ficate be executed / Medical Examiner st the buriet-transit edical Examiner edical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest | C | or as a consequence of): or as a consequence of): or as a consequence of): | g Chol | læng | itis | onset and Deeth one dag |
| | Todaking in dooding 2001 | d | | | | | 1 |
| P.O. het the detached by the d | Part II. Other significant conditions of | ontributing to death but not resi | ulting in the underlying caus | e given in Pert I. | 23b. Dld to | _/ | ntributa to the causa of death? 3 ☐ Probably 4 ☐ Unknown |
| 0 8 80 0 | | | | 4 | 24a. Was a perfor | in autopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? |
| The pege | | | | | 1 □ Y | es 2 No | 1 ☐ Yes 2 ☐ No |
| Of Vital I Physician: The rthis certificate and director, peg. | 25. Was case referred to medical exeminer? | Hospital: | | Other | eth (Check only or | | |
| H le | 1 Yes 2 No 27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Dey Year) | ER/Outpatient 3 DOA 28b. Time of lnjury M | Injury et Work? 1 Yes 2 No | lome 5 Reside | | |
| Division of but or Attending P is after death. In Director: After the led in by the funers Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Plece of Injury - At he building, etc. (Specify | ome, ferm, street, fectory, of | fice | 28f. Location (Si City or Town | | per or Rural Route Number, |
| To the Hospital of within 24 hours at To the Funeral D completely filled I | (Check only 2 Medical Exam | ysician: To the best of my knowinar: On the basis of examinal and manner stated. | tion end/or Investigation, In | my opinion, death occu | rred at the time, d | ate end plece, | end due to the cause(s) |
| To the com | 29b. Signature and fills of chriffier | nanda | M (M) 29c. Li | D 2010 | 8 2 | 1/26 | d (Month, Day, Year) |
| 0 | 30. Name and address of person who of Rakesh Arora, M.D. | completed cause of deeth (Item . 14300 Galla | n 23a) (Type, Print) nt Fox Lane, | #222, Bow | ie, Maryl | Land 20 | 715 |

Registrar

JAN 2 8 2000

May R A gran

| Amond #2 | Dow Dhar DCC 1 27 | State of Marylar | | artment of | | and Mental Hy | - 00 | 01 | 098 | |
|---|---|--|----------------------------------|---|---------------------------------|--|--|---|---|--|
| Physician | Per Phys. PGC 1-27- 1. Decedent's Neme (First, Middle, Last, Kenneth Elwood | | | unouto or | Dout | 2. Dete of D Month | | 000 | 3. Time of Death 2:50 PM | |
| /Medical Examiner | 4e Facility Neme (If not institution, give | street end number) | | | | January wn, or Location of Dea | th 4c. County | of Death | | |
| Funeral | Manor Care of Whe | 7. Age (In yrs. | lasf birthday) Yrs. | If Under 1 Yea Months Deys | | | | 9. Birthpla | ce (State or Foreign | |
| Director | 083-30-1839 | 01 | ty, Town or Lo | cation | | August | 3,1938 | | d. fnside City Limits | |
| or 28a-f sho be notified at Director | Maryland Montgomer | | lver S | pring | | | 1 Yes 2 No 10g. Citizen of What Country? | | | |
| | 10e. Street and Number 8811 Colesville R | oad #1125 | | | 910 | | U.S. | Α. | | |
| 5-0020 72 hours after death v 72 hours after death v 84st Examiner must red by Funeral | 11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 12 Yes 2 No Res If Yes, Give Yeer or Detes: | serves | Wes Decedent of f Yes, specify Cu 1 ☐ Yes 2X No | | gin? (Specify Yes or N i, Puerto Rican, etc.) | | e - America ck, White, et y:Black | c. | |
| 1121 mention than the Man | 15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12) | cation e completed) College (1-4or 5+) 2 yrs. | (Give | dent's Usuel Occu kind of work done DO NOT use retire Sman | ipation e during most ed) | t of working | 16b. Kind of B | | istry | |
| /land 2 uld be filled dental Hyginthed other file event, 1 | 17. Fether's Neme (First, Middle, Last) Al Joseph Dean | | | | | r's Neme (First, Middle ances Matil | | 10) | | |
| Mary nd 2 sho uth and 3 27 is me r treume | 19a. Informant's Neme/Reletionship (Ty Wanda Thomas/Daugh | | | | | #5B, Bron | | | | |
| Pages 1 a hert of Hea mrt. If Heam ury or other | 20a. Method of Disposition 1 Buriel 2 Cremetion 3 A 4 Donetion 5 Other (Specify) | 20b. I | Plece of Dispo cemetery, cres | sition (Name of metory or other pl | ace) | Dete n 1-20-00 | 20c. Location - | City or Tow | | |
| Balt permit Depart Importu | 21. Signeture of Funerel Service License | baxtor | | | l's Fu | y neral Home Road, Suit | -lond M | 207/ | . 6 | |
| Physician /Medical Examiner | 23a. Pert1. Enter the disease, or complishock, or heart feiture. List only or immediate Ceuse (Finet disease or condition resulting in death) | Lung | Cance | er the mode of dy | ring, such es | cardiec or respiretory | errest. | 1 (| Approximate ntervat Between Onset and Death | |
| 760, te be executed ysician and ne burial-transit | Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury | Due to (| or as e conseq | quence of): | | | | t 1 | | |
| F 5 8 5 | that initiated events resulting in death) Last | Due to (c | or as e conseq | uence of): | | | | 1 | | |
| S, P.O. Box 68 ss that the death certifica gned by the attending ph be deteched for use as it by Physician/Med | Pert If. Other algnificant conditions con | tributing to death but not res | ulting in the u | nderlying cause g | iven in Pert I | . 23b. Dfc | l tobacco une co | ntributa to t | the cause of death? | |
| ords, P.O. requires that the deen signed by the nould be deteched | | | | | | | | | ably 4 € Unknown | |
| aw aw | | | | | | 24a. We per | s an autopsy tormed? | com | e autopsy findings lable prior to pletion of cause eath? | |
| | 25. Was case referred to medical | | | | 26. Place | 1 □ of Death (Check only | Yes 2 No | 10 | Yea 2□ No | |
| 0 5 5 7 | exeminer? 1 Yes 2 No 27. Menner of Death | ospitel: 1 Inpatient 2 28a. Dete of Injury (Month, Day Year) | ER/Outpatier | IL 30 DOA | | rsing Home 5 Res | how injury occur | | | |
| Division of the hospital or Attending P n 24 hours after death to Functed Director: After the pletely filled in by the funera edical Certification: | 1 Accident 3 Suicide 4 Homicide 1 Aveturef 5 Pending Investigetion 6 Could not be determined | (Month, Day Year) 28e. Plecs of Injury - At h building, etc. (Speci | | M 1[| Yes 2 | 28f. Location | (Street and Numi | ber or Rural | Route Number, | |
| Division to the Heapital or Attendation within 24 hours after death or to the Funeral Director: completely filled in by the Medical Certifical | (Check only 2 Medical Examin | Icfan: To the best of my knower: On the basis of examine | wledge, death | n occurred at the | time, dete en | d place, and due to the | e cause(s) and m | anner as sta | ited. | |
| To the I within 2 To the Complet | 29b. Signefure and title of cartifier | end menner steted. | | | nse number | | 29d. Date signe | d (Month, D | ley, Year) | |
| (0) | 30. Neme and address of person who co | | | Print) | | Rockville | | | | |
| State Registrar | 31. Dafe filed (Month, Dey, Year) JAN 2 4 2000 | 32. Registrer's Signa | ature | Lock | 99 49 | | | | - 74 | |

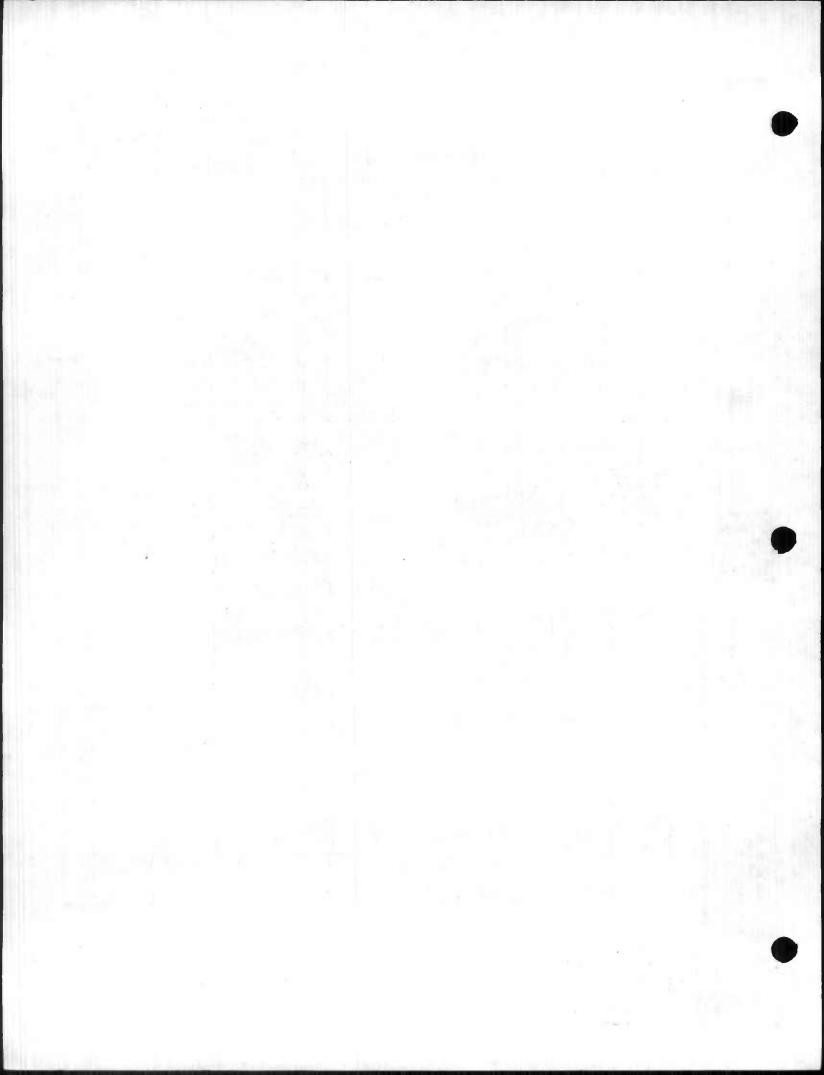
DHMH 16 Ray 6/95

1 2 ma.

| Dhusisian | Decedent's Neme (First, Middle, I | Last) | Certino | ate of Death | 2. Date of De | Reg. No. | 3. Time of Death |
|--|--|---|--|--|--|--|---|
| Physician /Medical | FREDERICK FRAM | IKLIN DEMARR | | | JANUARY | 30, 2000 Year | 12:30 PM |
| Examiner | 4e Facility Name (If not institution, g | | | | or Location of Deeth | | oth |
| | SOUTHERN MARYLAN 5. Sociel Security Number 6 | | | CLINT(| | PRINCE G | |
| Funeral Director | 215-26-0522 Usuel Residence of Decedent | 10 M 2 F 83 | Yrs. (est birthdey) Mor | | n. MARCH 2 | 9, 1916 MA | httplace (Stele or Foreign ountry) RYLAND |
| the Maryland 28a-f show notified at | 10a. Stete 10b. County MARYLAND CHARLE | | City, Town or Location | | | | 10d. Inside City Limits |
| E 5 E | 10e. Street and Number 16205 WILKERSON | PI ACE | 10 | . Zip Code 20613 | | 10g. Citizen of Whet C | ountry? |
| her death vine 23e sher mast. | 11. Meritel Stetus | 12. Was Decedent Ever in | U,S. 13. Was D | ecedent of Hispanic Origin? | (Specify Yes or No | 14. Rece - Am | |
| by | 1 Never Married 2 Merried 3 🌣 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No 11 Yes, Give Yeer or Detes: | | specify Cuban, Mexican, Pue os 2 No Specify: | erto Hican, etc.) | Specify: | WHITE |
| ed within 72 ho ygiene. wr than "naturn 4, the Medical Completed | 15. Decedent's (Specify only highest g | Education grede completed) College (1-4or 5+) | life. DO NO | Usuel Occupation If work done during most of w OT use retired) | vorking | 16b. Kind of Business | Andustry |
| | 4 17. Father's Name (First, Middle, La | st) | FARMER | 18 Mother's N | eme (First Middle | AGRICULTU Maiden Sumeme) | RE |
| hould be fi d Mental H marked of martic aver To Be | | EMARR | 401-14-11-44 | IDA MA | AE THOMPS | ON | 7.0.4 |
| and 2 sells and 2 sells and 2 sells and 27 le r | ELLA MAE DEMARR/ | | | ress (Street end Number or I LKERSON PLACE | | | |
| If Nem or oth | 20a. Method of Disposition 1 X Burlel 2 ☐ Cremetion 3 | Removel from State | Plece of Disposition cemetery, cremetory | or other plece) | Dete | 20c. Location - City or | |
| artmen ortant: injury | 4 Donation 5 Other (Spec | oify) IRI | | RIAL GARDENS e end Address of Fecility | 2/03/200 | O WALDORF, | MARYLAND |
| JP | · Aller Frace | LEV M01164 | THE I | JUNTT FUNERAL | HOME, IN | C., POST 0 | FFICE BOX |
| | 23a. Pert1. Enter the disease, or co shock, or heart feilure. List on | | oth. Do not enter the | WALDORF, MARY mode of dying, such es cardi | ec or respiretory as | 0U4-U155 rest, | Approximete Intervel Between |
| Physician /Medical | Immediate Cause (Finel | - | 2 | | | | Onset and Death |
| Examiner | disease or condition resulting in death) | a. Out | or es e consequence | ibRilate | 02 | | the Know |
| al si ed | | al | ute Re | mal Fair | line | | Whow |
| be avacuted sician and burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | or es a consequence | of): | | | |
| m Kig B | Cause (Diseese or injury that initiated events resulting in deeth) Last | | or es a consequence | Cymra of): | | | withrough |
| death certificate e attending phys od for use as the sician/Medic | resulting in deelin) East | ■ d. | | | | | 1 |
| attending for use as clan/Me | Death Observed Williams | | | | 1 | | Ī |
| that the death certi ed by the attending detached for use a Physician/M | Pert II. Other algnificant conditions | contributing to death but not re | sulting in the underly | ng cause given in Part i. | | | e to the cause of death? Probably 4 Pronknown |
| bed by | - Ul ma | ha | | | - | | |
| 2 2 S | | | | | | an autopsy med? | Were eutopsy findings evailable prior to completion of cause of deeth? |
| The ta | | | | | 101 | res 2 No | 1 Yes 2 No |
| ., 0 - | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospitel: | 7.50/0 · · · · · · · · · · · · · · · · · · | Other | eeth (Check only o | | |
| certificate irector, pag | | 28a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | DOA 4 Nursing 28c. Injury et Work? 1 Yes 2 No | 1 | dence 8 Other (Spenow injury occurred | ecify) |
| hysician: his certific al director. To Be | 27. Menner of Death 1 Netural 5 Pending | | M | | | | |
| or Attending Physician: after death. Director: After this certific i in by tha funeral director. ertification: To Be | 27. Menner of Death 1 ☑ Netural 5 ☐ Pending | on be | | ctory, office | 28f. Location (S City or Tox | Street end Number or F vn, Stete) | iurel Route Number, |
| or Attending Physician: after death. Director: After this certific i in by tha funeral director. ertification: To Be | 27. Menper of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying F | on | nome, ferm, street, fa | red at the time, date and place | City or Tov | vn, Stete) | s stated |
| hysician: his certific al director. To Be | 27. Menper of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examples | 28e. Plece of Injury - At the building, etc. (Special Physician: To the best of my knumer: On the basis of examin | nome, ferm, street, fa | red at the time, date and place | City or Tow ce, and due to the curred et the time, | vn, Stete) | s stated. e to the cause(s) |
| or Attending Physician: after death. Director: After this certific i in by the funeral director. ertification: To Be | 27. Menper of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Menper of Death 5 Pending investigeti 6 Could not determine | 28e. Plece of Injury - At the building, etc. (Special Physician: To the best of my knumer: On the basis of examin | nome, ferm, street, fa | red at the time, date and plaction, in my opinion, deeth occ | City or Tow ce, and due to the curred et the time, | m, Stete) cause(s) and manner a dete and place, and du | s stated. e to the cause(s) |

DHMH 16 Rev 6/95

DemARK Frednik



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Date of Death 3. Time of Death **Physician** Jan. 23, 2000 ALEXANDER DRAYTON 9:26 am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | Months | Deys 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 9, 1921 Birthplace (State or Foreign Country)
 S . C . **Funeral** 1₽M 2□F Hours 78 579-18-1251 Director Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 28a-f ahow D.C. Washington none 1X Yas 2 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20020 3648 Southern Ave. S.E. U.S.A. hems 23a death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispantc Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filled within 72 hours after nent of Health and Mental Hygiene. nn: If frem 27 le marked other than "natural", or its 1 Nes 2 No If Yas, Give 45-46 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3X Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Shipping Clerk Gov. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOses Drayton Bessie James 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e :: If item 27 le 4617 5th St.N.W.Wash.D.C.20011 Willie Drayton Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other place)
Resurrection Cem. permit. Page Department o Important: If I any Injury or page. M Burial 2 Cremation 3 Removal from Stete Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuperal Sarvice Licenses Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Human Immunodeficiency Virus yenk disease or condition resulting in death) Examine Due to (or es a consequence ot): Examine physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medicai that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown itypertension signed b Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Heputito's B completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital ospital or Attending Physician: hours after death. Inerel Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatienf 3 DOA 27. Manner of Deeth 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural

5 Pending investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicida 4 | Homicide

29s. Certifier (Check only one)

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier

29c. License number

1 (Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) JANUARY ZY 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVORE MD

4203 QUEENSBURY Rd Hyattsville MDZOZI

State Registrar

in 24 hour.
The Funeral Director of the Funeral Direct

To the Hosp within 24 ho To the Fune completely li

Medical

Hospital

31. Date filed (Month, Day, Year) JAN 2 8 2000 32. Registrer's Signeture

28e. Pleca of fnjury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month **Physician** 2000 11:10p.m. Rufus Michael Ellis /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton, Md. If Under 24 Hrs 5. Social Security Number if Under 1 Year Data of Birth (Month, Day, 03 20 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Year) 1901 Days Months Hours 1 M 20 F 98 Panama 577-02-2271 Director Usual Rasidance of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Slele Maryland 10b County Prince George's Fort Washington 1 Yes 2 □ No Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be r 9904 Jacqueline Drive 20744 USA Funeral thems: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after thant of Health and Mental Hygiens.

ant if Item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examics 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: 1 Nevar Married 2 Married 21215-0020 1 ☐ Yas 2 ☑ No Specity: Specify: Black py 3 ₩idowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Canal Zone Elamantary/Secondary (0-12) College (1-4or 5+) US Government Boat Man 6th Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumeme) 88 Victoria Forbes Samuel Ellis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Jacqueline Drive Ft. Washington, Md 20744 19a. Informant's Name/Raletionship (Type, Print) Florence Clark / Daughter 20b. Place of Disposition (Nema of cematary, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Important: If Peany Inter 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1 - 25Suitland, Maryland Washington National 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Marshall's Funeral Home 4308 Suitland Road Suitland, Md. 20746 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or have feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immedieta Causa (Finat disaasa or condition resulting in death) THE PANCREAS /Medical CANCER Examiner Examiner or Attanding Physician: The law requires that the death certificate be assouted burial-transit and Sequantially list conditions, if any, leeding to immadiata cause. Entar Undarfying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of) for use as Part ff. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital funeral director, Be 25. Was casa refarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 1 Yas 2 No 1 SInpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 Natural To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. edical (Check only one) 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-18545 30 Nama and eddrass of person who completed causa of death (Item 23a) (Type, Print) Pata Blad (Marth Day Yage) 32 OUD LINE CENTER WALDONE, Md. 12070 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State JAN 2 4 2000 Registrar

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JAN 2 4 2000

State of Maryland / Department of Health and Mental Hygiene

| Physician /Medical Examiner Uneral rector | Karin Foote 4e Facility Neme (If not institution, g 7506 Old Chapel 5. Social Security Number 289 36 7850 | |) | | | | Jan. | 24 2 | Year 2000 1:00 P |
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| neral rector | 7506 Old Chapel 5. Social Security Number 6. | |) | | | | | | |
| or 284-f show be notified at coctor | 5. Social Security Number 6. | Drive | | | 4 | b. City, Town, or | Location of Dee | th 4c. County | of Deeth |
| Director | 5. Social Security Number 6. | DITAG | | | | Bowie | | Prince | George's |
| or 28s-f show be notified at Director | | | ge (In yrs. ias 66 | | Undar 1 Yaar onths Deys | If Under 24 Hrs Hours Min | . (Month, D | | Birthplece (State or For Country) Germany |
| or 28a- | Usuel Residenca of Decedent | | | | | | Aug | | Germany |
| or 28a- | 10a. Stete 10b. County | | | Town or Locatio | n | | | | 10d. Inside City Lir |
| a or 28 be no | Maryland Prince | George's | Bow | ie | | | | | Yes 2□ |
| -9 - | 10e. Street and Number | | | 10 | Of. Zip Code | | | 10g. Citizan of V | Vhat Country? |
| 23.8 | 7506 Old Chapel I | rive | | | 2071 | .5 | | United | States |
| by Funer | 3 ☐ Widowed 4 ☐ Divorced | 12. Wes Decedent Armed Forces 1 Tyes 20 If Yes, Giva Year or Dates: | ? | | Decedant of H s, specify Cuba res 2 No | ispanic Orlgin? (nn, Mexican, Pual Specify: | Specify Yes or N nto Rican, etc.) | o- 14. Rac Bled Specify | e - American Indian, ck, White, etc. |
| ted | 15. Decedent's | | | 16e. Decedent's | Usuel Occup | etion during most of wo | ndkin o | 16b. Kind of Bu | usiness/Industry |
| n, the Medical I | (Specify only highest g | College (1-4or | 5+) | life. DO N | OT use retired | during most of we | nnig | | |
| Comp | 12 | 2 | | Homemal | ker | | | Own Ho | ome |
| Be | 17. Father's Neme (First, Middle, La. | et) | | | | 18. Mother's Na | me (First, Middle | e, Maiden Sumam | 10) |
| 10 | Victor v d Marw | tz | | | | Olga Ma | arie vor | Gottber | g |
| orner traumatic event, | 19e. Informent's Neme/Reletionship | (Type, Print) | | | | | | ber, City or Town, | |
| | Gerald T. Foote | Husbai | | 7506 0 | ld Chap | el Driv | e Bowie | Maryland | 1 20715 |
| 5 | 20a. Method of Disposition 1 △ Burial 2 □ Crametion 3 | | 20b. Ple | ca of Disposition netery, cremator | y or othar place | [≫] Jan. 2 | 7. 2000 | 20c. Location - | City or Town, Steta |
| once. | 4 Donetion 5 Other (Spec | | | | | Garden | | Davidso | onville MD |
| be deteched for use as me buner-transit by Physician/Medical Examiner | Ceuse (Disease or injury thet initiated events resulting in deeth) Last | e. Mc | Due to (or e | s e consequences e co | (4) (2) (4) (5) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6 | rcino mg | m 9 | | onset and Deeth |
| pieted | | | | | | | per | s en eutopsy formed? | 24b. Were eutopsy findin evailable prior to completion of cause of deeth? |
| Be Com | 25. Wes case referred to medical | | | | | 26. Place of De | eth (Check only | one) | |
| ē 2 | axaminer? | Hospitel: 1 Inpat | ient 2 El | R/Outpatient 3 | DOA Oth | Or: | - | sidenca 6 □Oth | er (Specify) |
| | 27. Menner of Deeth | 28e. Dete of Inj (Month, D | ury 2 | 8b. Time of Injury | 28c. Injur | y at | 28d. Describe | how injury occur | red |
| atio | 1 Neturel 5 Pending investigat | | ay roar) | Nijory | | Yes 2 □ No | | | |
| Medical Certification: | 3 Suicide 6 Could not determine | d 286. Pieca of in | jury - At hom tc. (Specify) | e, ferm, street, f | ectory, office | | | (Street and Numb own, State) | per or Rural Route Number, |
| Cal | (Check only 2 Medical Ex | | of examinetio | edge, deeth occ n end/or investig | urred at the tir getion, in my o | ne, dete end pled plnion, deeth occ | e, and due to the | e cause(s) end me | enner es steted. and due to tha cause(s) |
| Med | one) | and mannar s | tatad. | | 00-11 | | | and Data since | d (Marth Day Varia |
| - | 29b. Signature and title of cartifier | 4. | | 0 | 29c. Licens | e number | 11 | 290. Dete signe | d (Month, Day, Year) |
| 1 | David M. | Joldma | m, M | .10- | DOO | 043/ | 7 | 1 /2 | beHMd |
| 1 | | completed cause of | dooth /Itom ? | 0-1 /T 5 · · | | | | | |

JAN 2 1 2000 James & wanter

The rest had properly benefits

process of the forest

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 23, Anne M. Fitzgerald 4:30 AM 2000 Jan. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis

If Under 24 Hrs. | 8.1 Anne Arundel If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F Director 022-05-9050 83 05-08-1916 Massachusettes Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 Yes 2 No Directo 28a-f Md. Prince georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Name 23a 12319 Rambling Lane 20715 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 2 No if Yes, Give Year or Detes; Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 72 hours after 1 Never Merried 2 Married "natural", or 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Hygiens. Other than 'n Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be fill ment of Health and Mental H tem 27 is marked oth lury or other traumatic even Be Stephen Martin Mary Smiganowska 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 4th Street NE Washington, D.C. 20002 Martin Fitzgerald/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 01+28-00 Bowie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Snannon W. Beall M00798 6512 N.W. Crain Hwy. Bowie, Md.

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20715 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet 2days Keapuaton men disease or condition resulting in death) Examiner Examiner Small Cal physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 to bullation nec Physician/Medical Due to (or as a consequence of) 88 080 signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to bloods 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: | Impatient 2 | ER/Outpatient 3 | DOA 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: After 5 Pending investigation 1 Netural ie Hoepital or Attenuma in 24 hours after death. the Funeral Director: Aft NIA 1 TYes 2 TNo 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steted. Medical 29a. Certifier completely (Check only one) To the Within 2 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of curtiling 1/23/00 D3903 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S MITCHELL AAMC ANNAPOUS MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene 00

| | 1. Decedent's Nema (First, Middla, Las | t) | | | | 2. Data of Dea | | | Time of Death | | |
|---|--|--|------------------------------------|---|--|---------------------------------------|------------------------------------|---|---|--|--|
| Physician /Medical | HAZEL C. FRAWLEY | Y | | | | JANUAR' | Y 23, 20 | Yaar DOO 1 | 0:45 A.M. | | |
| Examiner | 4a Facility Name (If not Institution, give | street and number) | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | |
| | MALCOLM GROW MEDIC | | | T William A War | CAMP SPR | INGS | | CE GEOR | | | |
| Funeral Director | 5. Social Security Number 6. Security S | | yrs. last birthde 32 Yrs. | y) If Undar 1 Yaa Months Dey | | | 7, Year) 1917 | 9. Birthplaca Country WILSON, | (State or Foreign | | |
| 9 8 4 | 10a. Stata 10b. County | 100 | c. City, Town or | Location | 11000 | | | 10d. I | Inside City Limits | | |
| Maryland of show fied at tor | MARYLAND PRINCE GI | EORGE'S | MORNIN | IGSIDE | | | | 1 | Yes 2□No | | |
| th with the Ma 23e or 28e-f s ast be notified all Director | 10e. Street and Number 4009 FOREST GRO | VE DRIVE | | 10f. Zip Code 207 | | | 10g. Citizen of V USA | Vhet Country? | | | |
| hours after death with the Marylan hours after death with the Marylan at Examiner must be notified at bd by Furneral Director | 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced | 12. Was Decedent Evar Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Dates: | in U,S. 13 | B. Was Decedent of If Yas, spacify Cu 1 ☐ Yes 2 ☑ N | f Hispanic Origin? (Suban, Mexican, Puer o Specify: | Specify Yes or No- to Ricen, etc.) | 14. Raci Blec Specify | e - American Ir k, White, etc. WHIT | | | |
| ad within 72 hours at riginary, or it than "natural", or it, the Medical Exam? Completed by F | 15. Decedent's Edi (Specify only highest grad Elementary/Secondery (0-12) 12th | ucetion de completed) Collega (1-4or 5+) | | edent's Usuel Occ ve kind of work don DO NOT use reti | upation e during most of wo red) DERATOR | orking | 16b. Kind of Bu | | у | | |
| | 17. Father's Name (First, Middle, Last) | | 1151 | ILL HONE O | | me (First, Middle, | Maiden Sumem | (e) | | | |
| yidany build be fil Mental H mental de mental de de de de de de de de de de de de de d | JOSEPH M. HENRY | | | | | MAE DAUG | | •, | | | |
| H GREE | 19e. Informent's Name/Relationship (T | ype, Print) | 19b. Ma | iling Address (Stre | et end Number or R | lural Route Numbe | er, City or Town, | Stete, Zip Coo | de) | | |
| CTN L | WILLIAM G. FRAW | LEY/ HUSBANI | 400 | 9 FOREST | GROVE DR | IVE MORN | INGSIDE | , MD 2 | 20746 | | |
| 2 元 五 号 | 20a. Method of Disposition 1X Burial 2 Cremation 3 4 Donetion 5 Other (Specify, | Removal from State | cemetery, ci | position (Nama of rematory or other p VETERAN | | Date 1-27-00 | 20c. Location - CHELTE | | | | |
| permit. Page Department of Important: If sery Injury or once. | 21. Signature of Funeral Service Licensee 22. Neme end Addrass of Facility MARSHALL'S FUNERAL H 4308 SUITLAND RD. SUITLAND, MD 207 | | | | | | | | | | |
| Physician | 23a. Part1. Entar tha disaase, or comp shock, or heart failure. List only of | dications that caused the one cause on each line. | death. Do not e | inter the mode of d | ying, such as cardia | c or raspiratory ar | rest, | Inte | proximate erval Between set and Death | | |
| /Medical Examiner | Immediate Ceuse (Finel disease or condition resulting in death) RESPIRATORY FAILURE | | | | | | | | | | |
| | resulting in death) | Due | to (or as a cons | equence ot): | | | | ı | | | |
| min min | | b. PNEUMONIA | | | | | | 2 [| DAYS | | |
| executive in and institute Exam | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avents | | to (or es e cons | | OF 11010 | | | | | | |
| tificate be executed as the burial-transit | Ceuse (Disease or injury that initiated avents resulting in death) Last | c. SQUAMOUS Due | to (or as a cons | | OF LUNG | | | 1 M | MONTH | | |
| the death certification of the death certification of the attending letached for use as Physiclan/Me | W FIRE CO. | d | | | | | | 1 | | | |
| s dear he att he d fo | Pert II. Other algnificant conditions co | ntributing to death but no | t resulting in the | underlying ceuse | given in Part I. | 23b. Dld 1 | obacco use co | ntribute to the | cause of death? | | |
| | | | | | | 101 | Yes 2□No | 3 X Probabl | y 4⊟Unknown | | |
| aw requii | | | | | | 24e. Was perlo | an eutopsy med? | availab | autopsy tindings bla prior to etion of ceuse th? | | |
| The Page | | | | | | 101 | res 2 XNo | 1 □ Ye | es 2 No | | |
| clan: artific ector. | 25. Was cese referred to medical axaminer? | Mospital. | | | - | eath (Check only o | ne) | | | | |
| T sign | 27. Manner of Death 12. Natural 5 Pending | Hospitel: YInpatient 28a. Dete of Injury (Month, Dey Yea | 2 ER/Outpet 28b. Time Injury | of 28c. In | | Home 5 Resid | dence 6 Oth | | | | |
| tal or Attending Physics at after death. In Director: After this cled in by the funeral directors of the Certification: To Certification: To | 2 Accident investigation 3 Suicida 6 Could not be 4 Homicide determined | 28e. Plece of Injury - building, etc. (S) | | | | 28f. Location (S City or Tox | Street and Numb vn, Stete) | per or Rural Ro | outa Number, | | |
| To the Hospital or Thin 24 hours after To the Funezal Dir Completely filled in Medical Cert | 29a. Certifier XX Certifying Phy (Check only 2 Medical Exami | raician: To the best of my iner: On the basis of exa and menner stated. | knowledge, demination and/or | eth occurred et the investigation, in my | time, date end plac y opinion, death occ | e, end due to the curred at tha time, | cause(s) and ma date end place, | annar as stated and due to the | d cause(s) | | |
| M M | 29b. Signatura and title of certifier | 1- | | 29c. Lica | nse number | | 29d. Data signe | d (Month, Day | , Year) | | |
| 10 | 1 /homen X | Traser | | OH 2 | 5-07-0341- | _F | T A NITT A TON | 22 20 | 00 | | |
| (10) | 30. Neme and address of person who c | ompleted ceuse of death | (Item 23e) (Typ | e. Print) QQ MI | DC/1050 TI | DEDIMENT | JANUARY | 23, 20 | 00 | | |

Registrar DHMH 16 Rev 6/95

DOOS & S MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | Certifica | te of Death | violitai i iy | Reg. No. | 041 | 0.0 |
|------------|--|----------------|--|---|--|---------------------------------------|---|-------------------------|
| - | Dhuaia | | Decedent's Nama (First, Middle, Last) | | 2. Data of De Month | ath Day | Year 3. 1 | ima of Death |
| -1 | Physic /Medi | | HENRY BENJAMIN FISHER, SR. | | | 25, 200 | | :27 AM |
|) | Exami | | 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or I | Location of Death | 4c. County | of Death | |
| | | | HOLY CROSS HOSPITAL | SILVER SP | | | BOMERY | |
| | Funeral Director | | 5. Social Sacurify Number 249-44-3979 General Security Number 1 | ar 1 Yaar If Under 24 Hrs. B Days Hours Min. | 8. Date of Bin (Month, Da NOV . 23 | th y, Year) ,1931 | 9. Birthplaca (Country) SOUTH CA | Stata or Foreign |
| | dand dand | | 10a. Stata 10b. County 10c. City, Town or Location | | | | 10d. In | side City Limits |
| | the Manylar 28a-f show noutried at | Director | MARYLAND MONTGOMERY SILVER SPRING | | | | 15 | Yes 2□No |
| | or 2 | Dire | 10e. Street and Number 10f. 2 | ip Coda | | 10g. Citizen of W | | |
| | ath w | 2 | 3319 ESTELLE TERRACE | 20906 | | U. S. A | ١. | |
| 020 | within 72 hours after death with the Maryland ens. than "naturel", or items 23s or 28s-f show he Medical Exeminet must be notified at | by Funeral | 1 Never Married 2 Married 1X Yas 2 No | edent of Hispanic Origin? (Si ecify Cuban, Mexican, Puart 210 No Specify: | pecify Yas or No o Rican, etc.) | - 14. Race Blac Specify | BLACK | lan, |
| 5-0 | 72 hours "naturel", | ted | 15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of v | ual Occupation | tina | 16b. Kind of Bu | | |
| 21215-0020 | s 1 and 2 should be filed within 72 hr If Health and Mental Hygiena. Item 27 is marked other than "natur other traumatic event, the Medical | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | rork done during most of wor use retired) | King | OF LE | TUDE AVE | |
| | il Hygiena. other than rent, the M | CO | 2 YEARS BA | RBER 18. Mother's Nan | ne (First, Middle, | | EMPLOYE1 |) |
| Maryland | 2 should be f and Mental is is marked of aumetic ave | To Be | HAZE FISHER | MARIE | BYRD | | -7 | |
| ary | should by | - | | ss (Street and Number or Ru | | er, City or Town, | State, Zip Code |) |
| | 1 and 2 s Health ar em 27 le ther trau | Ì | HENRY B. FISHER, JR SON 3319 ESTE | LLE TERRACE | SILVER | SPRING. | MD 2090 | 16 |
| ore | of He | | 20a. Mathod of Disposition 1 ABurial 2 Cramation 3 Removal from State 20b. Place of Disposition (No cemetary, crematory or | ame of | Date | 20c. Location - | | |
| Ē | Pages nent of I ant: if its | | 4 Donation 5 Other (Specify) GATE UF HEAV | | 2/2/00 | SILVER | SPRING, | MD |
| Baltimore, | permit. Pages 1 and Department of Health Important: if them 27 any injury or other to | | | NEV-SPANGLER | | HOME | | |
| | HOISO | | /headone (IncRuly 524 - | 8TH ST., N. | E. WAS | H., D. (| 20002 | ? |
| | | | 23a. Part1. Entar the disease, or complications that caused tha death. Do no enter the meshock, or heart failure. List only one cause on each line. | ode of dying, such as cardiac | or respiratory a | rrest, | Appr | oximata ral Between |
| | Physician /Medical | | Immediate Cause (Final | 2 | | | Unse | t and Death |
| | Examiner | | diseasa or condition resulting in death) | trrevy | Disen | 52 | 10 | years |
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| | d d ansit | Examiner | Sequentially list conditions. Due to (or as a consequence of | ١, | | | | |
| o, | tificate be axecuted 9 physician and as the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of the injury that initiated events Due to (or as a consequence of the injury that initiated events) | <i>).</i> | | | | |
| 68760, | nte be nysici | edicai | Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of | <u> </u> | | | + | |
| | E 0 8 | Med | | | | | i | |
| Box | death cert a attendin sd for use | an/ | d | | | | | |
| | 0 00 2 | Physician/M | Part II. Other eignificant conditions contributing to death but not resulting in the underlying | cause given in Part i. | 23b. Dfd (| tobacco use con | tribute to the c | sues of death? |
| P.0 | res that the de- signed by tha a be detached f | | History UP Coronam Run | es Surge. | 10 | Yes 2 No | 3 Probably | 4 Unknown |
| ds, | signe d be | d by | History of Covenny By pr | - PV | / | | 24h Word au | oney findings |
| Records, | The law requires that the ate has been signed by the page 2 should be detache | Completed | IN REMOTE PAST | | perfo | an autopsy med? | 24b. Were eur available completi | prior to on of cause |
| Re | has ge 2 | du. | | | | | of death? | |
| B | | | OF West and the second of | | 101 | res 202 No | 1 🗆 Yas | 2□ No |
| of Vital | | o Be | 25. Was case referred to medical examinar? 1 Yes 2 Mo Hospital: 1 Innation: 2 EB/Outpetlent 3 BOY | 28. Place of Dea | | | And the second | |
| o | | - | 27. Mannar of Death 28a. Date of Injury 28b. Time of | OA 4LINUISING H | | dence 8 Othe | ~ | |
| on | Attending in death. | tion | 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident Investigation M | 28c. fnjury at Work? 1 ☐ Yes 2 ☐ No | | ,, | | |
| Division | To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Sulcida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify) | ry, office | 28f. Location (S City or Tox | Street and Number on, State) | or Or Rural Rout | a Number, |
| | Hospik 24 hour Funeri letely fills | edical | 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurre and manner stated. | d at the time, date and place, n, in my opinion, death occur | , end due to the cred at the time, | cause(s) and mar dete end place, e | nner es etated. nd due to tha ca | ruse(s) |
| | Nithin Nompi | Me | | c. Licensa number | | 29d. Date signed | (Month, Day, Y | ear) |
| | | | Charles L. Com | 0 8091 | / | JANUARY | 26 201 | 00 |
| | (10) | | 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) | | | | 20, 200 | |
| | | | CHARLES CURRY 2041 GEORGIA AVE., N. W. | WASHINGTON, I |). C. 20 | 060 | | |
| | Sta | to | 31. Date filed (Month, Day, Year) 32. Registrar's Signatura | | | | | |

STATE OF SHALL

| ne [] | U4: | 101 |
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|---|----|
| State of Maryland / Department of Health and Mental Hygiene | 00 |
| 0 110 1 10 11 | |

| | Certificate of Death Reg. No. | | | | | | | | THE PARTY OF | |
|---|--|--|-------------------|---|------------------------------------|--|---|--|--------------|---|
| | Decedent's Neme (First, Middle, Last) | | | | | | | 2. Dete of Deeth Month Dev Yea | | 3. Time of Deeth |
| Physician /Medical | Octavio Qui | ros I | Flores | | | | Januar | | 000 | 3:21 A.M. |
| | 4a Facility Name (If not institution | | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | |
| 49- | Johns Hopkin | - | | | | Baltimo | | N | | |
| Puneral Director | None | 6. Sex 1 M 2 F | Age (In yrs. last | | Under 1 Yeer onths Deys | | (Month, Da | y, Year) 22,1980 | Count | |
| | Usual Residence of Decedent 10a. State 10b. County | | 10c City To | own or Location | 00 | | | | 10 | Od. Inside City Limits |
| at at | | | | | | | | | | 1 Q Yes 2 No |
| be notified be notified Director | Md. | tmore | | | | 10g. Citizen of What Country? | | | | |
| D De | | | | | Of. Zlp Code | | | | | ·y· |
| 6 m 23 | 10.2 South register street 11. Meritel Status 12. Wes Decedent Ever in U.S. | | | 21 231 13. Wes Decedent of Hispanic Origin? (Specify Yes or N | | | | Mexico 14. Rece - American Indien, | | |
| Examiner must by Funeral | 1 Never Merried 2 Merri 3 Widowed 4 Divorced | Armed Forces 1 Yes 2 If Yes, Give | 1 TVec 2 Tilblo | | | ent of Hispanic Origin? (Specify Yes or No- fy Cuben, Mexican, Puerlo Rican, etc.) No Specify: Mexican | | Black, White, etc. specify: Spanish | | |
| ated a | 15. Decedent | | 10 | 6a. Decedent | 's Usuel Occu | pation during most of wor | rkina | 16b. Kind of Bu | usiness/Ind | ustry |
| Completed | (Specify only highes Elementery/Secondery (0-12) | College (1-4o | life. DO NOT use | | | ed) | Knig | | | |
| Con | 12 | | | La | borer | | | Odd Jo | bs | |
| Be | 17. Fether's Neme (First, Middle, I | ast) | | | 18. Mother's Neme (First, Middle | | | Maiden Suman | 10) | |
| 0 | Aron Quiros Os | sorio | | | | Regina | Mercede: | s Flores | Pera | alta |
| | 19e. Informent's Neme/Reletionsh | nip (Type, Print) | 1 | | | at and Number or Ru | | | | |
| ar trau | Regina Mercedes | Flores Pe | ralta | | _ | egister S | st. , Ba | | | |
| or other tr | 20e. Method of Disposition | | 20b. Pleca | ot Disposition of the other of | on (Name of any or other pla | eca) | Jan. 200 | 20c. Location | City or Tov | wn, Stete |
| 2 | 1 Buriel 2 Cremetion 4 Donetlon 5 Other (Sp | ecity) | Muni | cipal | Cemter | y Tlatenc | 0 | Puebla, | Mexi | 00 |
| 10 10 | 21. Signature of Funerel Service L | Icansee | | 00.01 | 1 4 4 4 | 15.00 | | | | , |
| 18 | 21. Signature of Funerel Service Licansee 22. Neme end Address of Fecility Garica Funeral Home Calz de Los Misterios #465, Col. Indus | | | | | | | | dustr | rial, Mexic |
| | 23e. Pert1. Enter the disease, or shock, or heert teilure. List | complications that caus | ed the deeth. D | o not enter th | ne mode of dy | ring, such as cardie | or respiratory e | rrest, | | Approximate Interval Between |
| the burial-transit | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | à | Due to (or es | a consequen | oca ot): | | | | | |
| dicai | cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or es e consequence of): | | | | | | | | | |
| igned by the attending p be detached for use as by Physician/Me | | d | | | | | | | | 4.1.1.025 |
| sed the | Pert ii. Other eignificant condition | one contributing to death but not resulting in the underlying cause given in Pert t. | | | | | 23b. Dld | tobacco uee co | ntribute to | the cause of death |
| detac detac | | | | | 11 | | | ☐ Yes 2☐ No 3☐ Probably 4] Unknow | | |
| d by | M P I'I | 246 | | | 24a Was | e. Wes en autopsy 24b. | | re autopsy findings | | |
| should should eted | | | | | | | | rmed? | ava | illable prior to npletion of cause deeth? |
| D 19 6 | | | | | | | X | | | |
| Com | | | | | | | 1 | Yes 2 No | TE | Yes 2 No |
| director, pag | 25. Wes case reterred to medical exeminer? | Hospitel: | v | | | | eth (Check only | one) | | |
| 1 P P P | 1 XYes 2 No | 1 U Inpa | | Outpatient | 3LI DOA | | lome 5 Resi | | | ') |
| unen unen | 27. Manner of Death 1 ☐ Neturel 5 ☐ Pending | 28a. Dete of In | ay Year) | , Injury , | Jnjury Work? | | | nibe how injury occurred | | |
| the Cat | 2 Accident investig | .40 A M 1 ☐ Yes 2 No | | | Subject Stabbed | | | | | |
| in by | 28e. Plece of Injury - At home, term, street, building, etc. (Specify) Street | | | | | reet, tectory, offica 28t. Locatic City or | | on (Street and Number of Aural Route Number, Town, State) IOU BLOCK South ter St., Baltimore, MD | | |
| | megester 5 | | | | | | | | | |
| S 5 | (Check only 2 X Medicat E | xaminer: On the basis | of examinetion | ige, deeth oo and/or invest | curred et the fi igation, in my | time, dete end plece opinion, deeth occu | e, end due to the urred at the time, | date and piece, | end due to | ated. the cause(s) |
| | one) and menner stelled. | | | | 29c. License number | | | 29d. Dete signed (Month, Day, Year) | | |
| Wedie te | 20h Cianatura and title at audities | 2 0 1/ | | | | | ense number 29d. Dete signed (No. C.M.E. January 24 | | | |
| To the Funeral Director. After the completely filled in by the funeral Medical Certification: | 29b. Signeture end title of certifier | el Kin | Lus , | | 0. | C.M.D. | | January | 24, 2 | 2000 |
| 7 | 30. Neme and address of person v | who completed cause of | deeth (Item 23 | a) (Type, Prin | | C.M.B. | | January | 24, 2 | 2000 |
| 1 | Theodon | who completed cause of ing, M.D. | eeth (Item 23 | | ot) | Street, B | | | | |
| 4) | 30. Neme and address of person v | ing, M.D. | beeth (Item 23 | 111 | ot) | Street, E | | | | |

State of Maryland / Department of Health and Mental Hygiene

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|---|---|---|----|---|---|---|
| 0 | U | U | 4 | 1 | | 1 |

| 1. Decedent's Neme (First, Middle, | | | | | Death | | FILE | g. No. | | |
|--|--|--|--|---|--|---|---|--|---|---|
| | | | | | | | Date of Deetl Month | h Day | Yeer | 3. Time of Death |
| | ruz Fejaran | | | | | 1 | NUARY | 23 20 | 00 | 10:30 P.M. |
| | | | | | | | | , | | |
| | | | t birthelast If | Under 1 Yea | | | | 1 | | |
| 579-52-9070 | 1⊠M 2□F | 79 | | | | Min. | | | Cour | place (State or Foreign ortry) Guam |
| | | 10c. City, T | own or Location | on | | _ | | | 1 | I Od. Inside City Limits |
| Maryland Prince | Georges | FT. | Washing | gton | | | | | | 1 ☐ Yes 2 ☐ No |
| 10e. Streel and Number 10f. Zip Code 10g. Citizen of What | | | | | | | | What Cour | ntry? | |
| 11308 Trafalgar Court 20744 USA | | | | | | | | | | |
| | d 1 Yes 2 If Yes, Give | 1962 | | | | gin? (Specify , Puerto Rica | Yes or No- in, etc.) | Blac | ck White | etc. |
| | | 1 | (Give kind | of work don | e during most | of working | | 16b. Kind of B | usiness/In | dustry |
| Elementary/Secondery (0-12) | | College (1-4or 5+) | | VOT use reti | red) | | | | | |
| 6 | | | Barber | | 10 14-01-0 | da Nama (Fi | | | - | |
| | | | | | | | | | | |
| | | | 10h Mailing A | ddraes (Stra | | | | | State 7ir | Code) |
| | | | | | | | | | D1010, 24 | 0000) |
| | (5011) | 20b. Plec | a of Dispositio | n (Neme of | | - | - | | City or To | own, State |
| | | 0 | | | | 02/ | 03/00 | Arling | ton, | Virginia |
| | | | | | | ss of Fecility Advent Funeral & Cremation Svcs. | | | | |
| Carter R. | Naggu | | 7211 | Lee | Highway | y Fall | s Chur | ch, Vi | rgini | ia 22046 |
| 23a. Pert1. Enter the disease, or of shock, or heart feilure. List of | omplications that cause | ed the death. I | Do not enter th | e mode of d | ying, such es | cardiec or re | spiratory erre | est, | | Approximete Intervel Between |
| | Dielo | | | | | | | | | Onsel end Deeth |
| disease or condition | ASPIRA | ATION P | NEUMON | [A | | _ | | | 1.0 | 30 MINUTES |
| resulting in death) Due to (or as a consequence of): | | | | | | | | | | |
| | b. CEREBE | | | | | | | | i | 3 WEEKS |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying | 1000 | Due to (or es | s e consequen | ce of): | | | | | | |
| that initiated events | c | Due to (or es | e consequent | ce of): | | | | | | |
| resulting in death) Last | 4 | | | | | | | | | |
| | | | | | | | | | | |
| Part II. Other eignificant condition | s contributing to death | tributing to death but not resulting In the underlying cause given in Part I. | | | | | | | | |
| | | | | | | | 1 🗆 🕶 | 200 No | 3 Pro | Dentity 4 Unknown |
| | | | | | | | | | 24b. W | ere eutopsy findings vailable prior to |
| | | | | | | | | | | ompletion of cause deeth? |
| | | | | | | | 1 □ Ye | s 2000 | 11 | ☐ Yes 2☐ No |
| 25. Wes case referred to medical | | | | | 26. Place | of Deeth (C | heck only on | e) | | |
| 1 Yes 2 No | 1 ps. inpai | | | 3LI DUA | 4 L NU | | | | | fy) |
| 1. Natural 5 ☐ Pending | (Month, D | jury lay Year) 28 | Injury | | | | Describe ho | ow injury occur | rred | |
| | ed 286. Pieca of I | 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Routa Number, City or Town, State) | | | al Routa Number, |
| (Check only 2 Medical E | 125 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) | | | | | | | | | |
| | and menner s | stated. | 14.70 | 29c. Lice | nse number | | 2 | 9d. Date signe | d (Month, | Day, Year) |
| 1 (2/2+) | milan | | | MD-0 | 57546-1 | L (| (PA) JANUARY 23, 2000 | | | 2000 |
| | and the same of th | | | | , | | | | , | |
| 30. Name and address of person w | ho completed cause of | death (Item 23 | 3a) (Type, Prin | 1)89 MD | G/1050 | W. PF | RIMETE | ER RD. | | |
| | MALCOLM GROW MED 5. Social Security Number 579-52-9070 Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 11308 Trafalgar 11. Marital Status 1 Never Married 2 Merrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondery (0-12) 6 17. Fether's Neme (First, Middle, Living | MALCOLM GROW MEDICAL CENTY 5. Social Security Number 579-52-9070 Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges 10e. Streel and Number 11308 Trafalgar Court 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 6 17. Fether's Neme (First, Middle, Last) Vicente Charsagua Fejarar 19a. Informent's Name/Relationship (Type, Print) Ronald J. Fejeran (Son) 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stat 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee | Usual Residence of Decedent 10e. State 10b. County Prince Georges FT. 11a Narital Status 1 | MALCOLM GROW MEDICAL CENTER 5. Social Security Number 579-52-9070 Sum | MALCOLM GROW MEDICAL CENTER 5. Social Security Number 5. Social Security Number 5. Type 52 – 90 70 10. State 10. Conty Maryland 10. County 11. Markal Status 12. Was Decedent Every N. U.S. Amed Frovers 13. Was Decedent of If Yes, Single State of Types, College (1-4or 5+) 13. West Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) College (1-4or 5+) Farber 17. Fether's Name (First, Middle, Last) Vicente Charsagua Fejarang 19e. Informent's Name/Relationship (Type, Print) Ronald J. Fejeran (Son) 20e. Method of Disposition 15 Buriel 2 © Cremetion 3 © Removel from State 4 © Donellon 5 © Other (Specify) 21. Signature of Funerel Service Licensee 12. Name Americal State Stripes on each line. 22. Name and Add 7211 Lee 23a. Pent; Enter the disease, or complication that initiated we wont in resulting in death) 25. Sequentially list conditions. If any, heading to immediate Cause (Final diseases or confliction) 18 any, heading to immediate cause (Final diseases or confliction) 25. Was case referred to medical wasminer? 19 Signature of Funerel Service Licensee 19 Cartifying Physician to the beat of my knowledge, deeth occurred at the cheermined of the beats of examiner of higher or interest of the confliction of the properties of the passion of examiner? 19 Signature of Certifying Physician. To the best of my knowledge, deeth occurred at the Cheer one of the beats of examiner or interest factory, official and menner stated. | MALCOLM GROW MEDICAL CENTER 5. Social Security Number 6. Sex 5. 79 – 52 – 9070 10 usual Residence of Decedent 10e. State 10e. County Arry Land Prince Georges 10c. City, Town or Location | ### ALCOLM GROW MEDICAL CENTER Social Security Number Social Security Number Social Security Number Social Security Number 579–52–9070 | 46. Failly Name (if not institution, give atwest and number) MALCOLM GROW MEDICAL CENTER Social Security Number 5. Social Security Number 6. Security Number 100. County 4. Type In you as a brindary) 100. City, Town or Location F. Washington 100. Street and Number 11. Marital Status 12. Wish Depocher Expert U.S. 13. Wee Depocher of Happenic Origin? (Specify Yee or No-Views peoply Culture) 14. Marital Status 15. Depocher Statustion (Specify Orly Infringer growth or Depocher) 15. Depocher Statustion (Specify Orly Infringer growth or Depocher) 16. Depocher First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street and Number or Rural Rates Number) 19. Mailing Address (Street And Number or Rural Rates Number) | 48 Facility Name (if not institution, give street and number) 40 Centre 40 Centre | 48. Facility Name of first institution, give street and number of National |

DHMH 16 Rev 6/95

Registrar

00-0286-033 00-017

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| | 9 | U | U | 1 . | | U | 1 |
| | | | | | | | |

| LEONARD GR | EENE Certificate of Death | Reg. No. | 0 1 1 0 0 | | |
|--|--|---|---|--|--|
| Dhuaisian. | 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Ye | 3. Time of Death | | |
| Physician /Medical | Leonard F Greene | JANUARY 17,2000 | 2 20- 24 | | |
| Examiner | | or Location of Death 4c. County of E | Death | | |
| <u> </u> | 4405 FLORAL PARK ROAD Social Security Number 6 Sex 7 Age (In vrs. last hirth/lev) If Under 1 Year 1 If Under 24 | Har I a market | GEORGES | | |
| • Funeral Director | | Hrs. 8. Date of Birth (Month, Day, Year) 9. | Birthplace (State or Foreign Country) | | |
| A Mand | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits | | |
| Mary Filed Stor | VA none Fredericksburg | | 1 Yes 2 No | | |
| ser death with the Maryle flerre 23e or 28e-f sho iner mast be notified at funeral Director | 10e. Street and Number 10f. Zip Code 22401 | 10g. Citizen of What | Country? | | |
| ther death in the rest of the | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuben, Mexicen, P | 7 (Specify Yes or No- | American Indian, Vhite, atc. | | |
| by B | 1 □ Never Married 2 Married 1 □ Yes 2 M No M Yes, Give 1 □ Yes 2 M No Specify: 1 □ Yes 2 M No Specify: | | | | |
| 72 h | 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | working 16b. Kind of Busine | ess/Industry | | |
| 21215-0 ad within 72 ho ygiana. or than natura f, the Medical. Completed | Elemantary/Secondary (0-12) College (1-4or 5+) | 1)-001 | Company | | |
| # 3254 O | 9 Direct Market | Name (First, Middle, Maiden Surname) | Compactly | | |
| d be | I G C C SI DAH | | can | | |
| To To | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street) | | son. | | |
| Maryl d 2 should d 2 should the and Me T is mark traumeth | | edericks burg. Vx | 22401 | | |
| 1 and 1 and Health Man 27 | 20a. Mathod of Disposition 20b. Place of Disposition (Name of | Data 20c. Location - City | or Town, State | | |
| Pages 1 ant of 14 mt. if iten ry or oth | 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removat from State cemetery, crematory or other place) | 1/24/200 Alexand | MA VA | | |
| mil. P. partms portant y Injury | 4 Donation 5 Other (Spacify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | GREENE FUNERAL HOME | ALA POLI | | |
| Dem Ospu Impo | Nelson & Greene g. | 814 Franklin Street Alexandria, VA 22314 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. | rdiac or respiratory arrest, | Approximate Interval Between | | |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. MULTIRE GUNSHOT Wound to (or as a consequence of): |)5 | | | |
| that the death certificate be executed that the death certificate be executed to the attending physician and tohed for use as the buriel-transit Pysician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | |
| he death certification to the attending placed for use as it ched for use and use an it ched for use an item fo | d | | | | |
| y the atter sched forysiciau | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. | 23b. Did tobacco use contril | | | |
| that the | | 1 Yes 2 X No 3 | Probably 4 Unknow | | |
| The law requires the law requires the law been significant page 2 should be Completed by | | 24a. Was an autopsy parformed? | 4b. Were autopsy findings available prior to completion of cause of death? | | |
| The law The law ate hes b page 2 s | | 17 Yes 2□ No | 1 Xyes 2□ No | | |
| = F # C | 25. Was case referred to medical 26. Place of | Death (Check only one) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| Physician: This certificate ral director, pt | examiner? | ng Home 5 ☐ Residence 6 🖫 Other (| Specify SC FINE | | |
| Phys eral di | 27. Manner of Death 28a. Data of Injury (Card) 28b. Time of (Fam) 28c. Injury at | 28d. Dascribe how injury occurred | - CENE | | |
| Attending or death. ector: After fune by the fune | 1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation 11000 2:55 PM 1 Yes 2 No | SUBJECT SH | or | | |
| S SES E | 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, farm, street, factory, office (family) building, etc. (Specify) | 281. Location (Street and Number or Rural Route Number, City or Town, State) 4405 FLORAL PK. READ | | | |
| To the Hospital within 24 hours To the Funeral completely filled | 29a. Certifier (Check only (Ch | place, and dua to the causa(s) and manne occurred at the time, date and place, and | er as stated. due to the cause(s) | | |
| the thin 2 the mplet | one) and manner stated. 29b. Signature and title of certains 29c. License number | 29d. Date signed (A | Anoth Day Year) | | |
| T N T S | 29b. Signature and title of cerular 29c. License number | Edu. Date signed (A | suy, rour/ | | |
| 5 | O.C.M.E. | JANUARY 18 | 3,2000 | | |
| (3) | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) | | | | |
| | | t, Baltimore, Mary | land 21201 | | |
| State | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | |

AAX III.

MAX II

| | | | | | Certifica | ate of | Death | R | eg. No. | | |
|-------------------|--|---|--------------------------------------|--|--|--|--|-------------------------------------|------------------|-------------|--|
| | Physician | 1. Decedent's Nama (First, Middle | , Last) | | | _ | | 2. Date of Deal Month | h Day | Year | 3. Time of Death |
| | Physician /Medical | IZADENI DE CEREN | | | | | | JANUARY | 22, 20 | | 2:37pm |
| | Examiner | 4a Facility Name (II not institution | , give street and number | er) | | | 4b. City, Town, or I | | 4c. County | of Death | |
| | | WASHINGTON ADVI | | | | 4-4 1 | TAKOMA P | | MONTO | | |
| и | Funeral | 5. Social Security Number | 1 DM 2F F | Aga (In yrs. I | Yrs. Monti | der 1 Year ns Days | If Under 24 Hrs. Hours Min. | (Month, Day, | | | placa (State or Foreign ntry) |
| Ш | Director | 577-06-8219 Usual Residence of Decedent | | 36 | | | | AUGUST | 15, 196 | 3 W | ASHINGTON I |
| | yland w | 10a. State 10b. County | | 10c. City | , Town or Location | | | | | 1 | 10d. Inside City Limits |
| | Mar | | | WAS | HINGTON. | D C | , | | | | Yas 2□No |
| | vith the Mai t or 28s-f o be notined | 10e. Street and Number | | | | Zip Code | | 1 | 0g. Citizen of \ | What Cour | ntry? |
| | th wi | | NW #104 | | 2 | 0010 | | UI | NITED S | TATE | S OF AMERIC |
| | 72 hours after death with the Maryland natural; or items 23s or 28s-f show deat Examinar must be notified at steed by Funeral Director | 11. Marifal Status | 12. Was Deceder Armed Force | nf Evar in U.S | 3. 13. Was De | cedent of I | dispanic Origin? (Span, Mexican, Puert | pecify Yes or No- o Rican, etc.) | 14. Rac | | can fndian, |
| 20 | urs afte | 1 Never Married 2 Marri | If Yes, Giva | | | 2 No | Specify: | | 1 | BLA | |
| 21215-0020 | natural', ratural', refret by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates | s: | 10- Deceded to | | | | | | |
| 15 | c - = - | 15. Decedent (Specify only highas | a Education t grada completed) | | 16a. Decedent's U (Give kind of life. DO NO. | suel Occuj work done Luse retire | during most of world) | king | 16b. Kind of Bi | JSINESS/IN | dustry |
| 212 | filed within 72 hours than "natural and, the Medical and, the Medical and a Completed | Elementary/Secondery (0-12) 12th grade | College (1-4o | or 5+) | FOOD SER | | 7 | | RIVATE | TMDI | ICTDV |
| | 年工女 6 | | .ast) | | TOOD BEK | V I.C.E. | 18. Mother's Nan | ne (First, Middle, M | | | ISTRY |
| Maryland | should be ad Mental marked o matic av | DANIEL HARRISON | GETER | | | | RUTH HI | CKS | | | |
| any | 2 should end Men la marke aumatic | 19a. Informant's Name/Relations | | | 19b. Meiling Addr | ess (Street | and Number or Ru | ral Routa Number | City or Town, | State, Zip. | Code) |
| | tr tr | KEVIN H. GETER | | | 425 W. S | IDE D | R. #203 (| CATTHERSE | IIRC M | D. 20 | 1878 |
| ore | 0 0 E | 20a. Method of Disposition 12 Burlal 2 Cramation | 2 Demousl from Sta | | ace of Disposition (I | vame of | ce) | CAITHERSE | | | |
| E | Pa | 4 Donation 5 Other (Sp | | HA | RMONY MEM | ORIAL | PARK 1 | /29/88 L | ANDOVE | R, MA | ARYLAND |
| Baltimore, | permit. Pag Department Important: I any Injury o | 21. Signature of Funerel Service I | itensee 1 | | | | ess of Facility JC | HNSON & | JENKIN: | S FUN | VERAL HOME |
| Ш | 20539 | Toulink | 2 Ph | LSON | 716 | KENNE | DY ST NW | WDC 2001 | 1 | | |
| | | 23a. Part1. Enter the diseese, or shock, or heart teilure. List | complications that caus | ed the deeth | Do not enter the m | ode of dyi | ng, such as cardiac | or respiretory arre | est, | | Approximate Interval Between Onset and Death |
| | Physician | | | 1 | 0 | | 0:1 | | | | Onset and Death |
| | /Medical Examiner | Immediate Cause (Finel disaasa or condition resulting in death) | · Cere | 6 620 | I Va | Sca | lotis. | | | | 1.5.2000 |
| L | 5 | | 000 | Due to (or | as e consequence | 200 | | - | | 1 | 1 1 1 1 |
| | executed in and instransit | | - b. HSP | 18a/ | ion / | ne | um02 | 219. | | | 1.4.2000 |
| | al-tra | Sequentially list conditions, if any, leading to immediate cause. Enfar Underlying Cause (Disease or Injury | / | Due to (or | as a consequence | of): | | | | 1 | |
| 68760, | | | с | Due to fee | | 0 | | | | - i | |
| 89 | ng physicie es the bu | resulting in death) Last | | Due to (or | as a consequence of | ч) : | | | | | |
| Box | attending for use | | d | | | | | | | - | |
| | nat the death cell of by the attendir letached for use Physician/ | Part II. Other aignificant condition | na contributing to death | but not resu | ting in the underlyin | a cause oi | ven in Part I. | 23b. Did to | bacco usa co | ntribute t | o the cause of death? |
| P.0 | by the stacks | P. 001 | 00 80 | . 0 | 0.500 | | 0 | 1 🗆 Y | 1- | 3 □ Pro | |
| | ± 00 | | Je ne | hal | ouse | as | <u>e</u> | | | | |
| of Vital Records, | law requires that the de as been signed by the second be detached by Physical physical by | | 1 | | | | | 24a. Wes a perform | | av. | ere autopsy tindings vailable prior to |
| ecc | has be | | | | | | | | | | ompletion of cause death? |
| = = | The page | | | | | | | 1 □ Ye | s 201No | 1[| □ Yes 2□ No |
| /ita | Physicien: The this certificate ral director, pare TO Be Co | 25. Was case referred to medical | | | | | | th (Check only on | e) | | |
|) t | hya his al di | -9 | Hospitel: 1 DAnpa | | | DUA | | ome 5 Reside | | | (y) |
| | Ing P Wher t uners uners | 27. Menner of Death Natural 5 Pending | | jury Day Year) | 28b. Time of Injury | 28c. Inju Wo | | 28d. Describe ho | w injury occur | red | |
| Sic | Attanding in deeth. ector: After by the funer iffication. | 2 Accident investig | of he | | М | | Yes 2 □ No | 006 Leastine (Ct | | | - (Do to Nonto |
| Division | 24 F E | 4 Homicide determi | and 286. Place of I | njury - At hor etc. <i>(Specify</i>) | ne, farm, street, fac | ory, office | | City or Town | , State) | er or Huri | al Route Number, |
| | Hospital 24 hours of Funeral I niely filled | 29a. Certifier 1 Certifying | Physician: To the bes | et of my know | ladae daeth soc | ad at the ti- | me date and alco- | and due to the | nucola) and — | 000000000 | stated |
| | n 24 hound no 24 h | (Check only 2 Medical E | xaminer: On the basis and manner: | of examineti- | on and/or investigati | on, in my | opinion, deeth occu | red at the time, do | ate and place, | and due to | o the cause(s) |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi | 29b. Signature and title of cartifier | | | | 29c. Licens | | 2 | 9d. Date signe | d (Month | Day, Year) |
| | ->-0 | XQue D. | '_ | | | 019 | 609 | T | AN 9 | 2 hal | 2000 |

State Registrar

31. Date filed (Month, Day, Year) JAN 2 7 2000

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)
RAMAN. R. TULI, ND 10810 D

m 23a) (Type, Print) 10810 Darnestown Rd. Gaithersburg, Ind.

JAN 2 7 2000 5

Funeral

Director

28s-f st notified

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or Rema

permit. Pages 1 and 2 should be fix Department of Health and Mental Hy Important: If New 27 is marked other any injury or other traumetic event.

Physician /Medical

Examiner

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page 2

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after death.

within 24 hours of To the Funeral D

To the

the

filled in by

completely

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

of Vital Records,

Division

72 hours after

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Desth Month **Physician** GRAY ALFONSO **JANUARY** 19, 2000 1029 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Yaar | If Undar 24 Hrs. Social Security Number 231-36-2960 Birthpiaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 6. Sex Months Days Hours 66 Mar. 15. Virginia Ususl Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TWas 2 No Prince George's Maryland Lanham Director 10f. Zip Coda 10e Street and Number 10a. Citizen of What Country? 3203 Reed St., #2844 20706 United States Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indisn, Black, White, atc. 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dalas: 1) Nevar Married 2 Married 1 Yas 2 No Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Maintenance Worker Private 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Sumama) Monroe Gray Ollie Finney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) Joyce Harrison / Step-daughter 3203 Reed St., #2844, Lanham, MD 20706 20b. Place of Disposition (Nama of cametary, crematory or other place) 20c. Location - City or Town, SIsla 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 1/29/2000 Landover, MD 4 ☐ Donation 5 ☐ Othar (Specify) Harmony Memorial Park 21. Signature of Funeral Sarvice Licensee 22. Nsma and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 10m 23a. Psrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Immediala Causa (Finsl disease or condition rasulting in death) Examiner VASC Sequentially list conditions, if sny, lasding to immediala cause. Enter Undarlying Ceuse (Diseasa or Injury that Initiated avants resulting in deeth) Last Due to (or es a consequença of). Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings 24a. Wes an autopsy complation of causa of death? tra 1 Yes 1 Yas 2 No 2 No 25. Was casa referred to medical 26. Pleca of Daath (Check only ona) Hospitel: 1 ☐ Inpaliant XX ER/Outpalient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) MYas 2□ No edical Certification: To 27. Manpar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Plece of Injury - Al homa, farm, street, fsctory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29s. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, deta and place, end due to the ceuse(s) and mannar as stsled.

XX Medical Examiner: On the basis of axamination snd/or invastigation, in my opinion, death occurred et the time, data and place, snd due to the ceuse(s) and mannar stated. 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier **OCME** JANUARY 20, 2000 rass of person who complated causa of death (Ilam 23a) (Type, Print) S tago111 Penn Street, Baltimore, Maryland 21201

Registrar

DHMH 16 Rev 6/95

Registrar's Signatura

proce to from

1**AH 2** 4 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Certificate of | of Death | F | leg. No. | 04111 |
|---|---|--|---|--|------------------------------------|-------------------------------------|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) Jowes 4a Facility Nama (If not institution, give street and num | ivey | | 4b. City, Town, or L | 2. Date of Dea | 20 2 | Year 1000 10 37 AM |
| Examiner | | | | | | | |
| Funeral Director | Howard County General Ho 5. Social Security Number 6. Sex 7 577-14-8615 1XD M 2 F | . Age (In yrs. last birt | hday) If Under 1 Yours. Da | | 8. Date of Birth (Month, Day | , Year) | 9. Birthplaca (State or Foreign Country) |
| CCIO | Usual Residence of Decedent | | | | Oct. 4 | 1919 | Wash., D.C. |
| H | 10a. Stata 10b. County | 10c. City, Towr | or Location | | | | 10d. Inside City Limits |
| tor | Maryland Howard | | Columbia | | | | 1 ☐Wes 2 ☐ No |
| I Director | 10e. Street and Number 5444 High Tor Hill | | 10f. Zip Coo | 21045 | | In f t | mat Country? |
| by Funeral | | No | 13. Wes Decedent If Yes, specify (| of Hispanic Origin? (Sp Cuban, Mexican, Puerto | pecify Yes or No- Rican, etc.) | | - American Indian, k, White, etc. African |
| Be Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/\$econdary (0-12) College (1- | | Decedent's Usual Oc (Give kind of work do life. DO NOT use re | cupation ne during most of work tired) | king | 16b. Kind of Bu | |
| E | Elementary/Secondary (0-12) College (1- | 101 54) | Police | Officer | | Gov | ernment |
| To Be C | 17. Father's Name (First, Middle, Last) Charles Leon Harvey | | | 18. Mother's Nam | | Maiden Sumam Lce Knor | f. |
| T | 19a. Informent's Name/Relationship (Type, Print) | | | eet and Number or Ru | | | |
| ž. | Pauline P. Harvey - Wif | | | Tor Hill, | | - | 21045 |
| 70.00 | 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from St 4 Donation 5 Other (Specify) | ate cemeter | Disposition (Name of crematory or other and Vetera | place) | /26/2000 | | city or Town, State |
| 를 | 21. Signatura of Funaral Servica Licensee | Haryra | 22. Name and Ad | | Stewart | | |
| any any | DI TA H | -111 | | nning Rd., | | | |
| | 23a. Part Enley the disease, or complications that car | used the death. Do n | | | | | Approximata |
| ician | shook) or heart failure. List only one cause on ear | ch line. | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | Interval Between Onset and Death |
| edical miner | Immediate Cause (Final disease or condition resulting in death) | s ralem | 2 | | | | 1 |
| | A - | Dua to (or as a | onsequence of): | | | | 7 |
| aria Pir | Rei Rei | raitai | Ivre | | | | |
| burial-transit | Sequentially list conditions, | Due to (or as a c | onsequence of): | | | | |
| | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c | | | | | | |
| edicai | that initiated evants resulting in death) Last | Due to (or as e c | onsequence of): | | | | |
| 9 | d | | | | | | |
| - Le | | | | | | | |
| Physician/ | Part II. Other significant conditions contributing to dea | th but not resulting in | the underlying ceuse | given in Part I. | 23b. Did t | obacco use con | tribute to the cause of death? |
| by Ph | Colon Cancer | | | | 101 | /es 2□ No | 3 Probably 4 Linknown |
| Completed by Physician/N | Aspiration Pneu | Monia | | | 24a. Was a perfor | an autopsy med? | 24b. Wera autopsy findings available prior to completion of cause of death? |
| Con | | | | | 1 U Y | es 20 No | 1 ☐ Yes 2 ☐ No |
| Be C | 25. Was case referred to medical | | | 26. Place of Dea | th (Check only o | ne) | |
| To Be | axaminer? 1 Yes 2 No Hospital: 1 | patient 2 ER/Out | patient 3 DOA | Other | ome 5 Resid | | er (Specify) |
| 65 | 27. Manner of Death 28a. Data of | | | njury at Work? | | ow injury occurr | |
| funer | 1 Natural 5 Pending (Month, 2 Accident investigation | Day Year) | | Yes 2 No | | | |
| empletely filled in by the funera Medical Certification: | 3 Suicide 6 Could not be | I Injury - At homa, fai , etc. <i>(Specify)</i> | m, street, factory, off | ce | 281. Location (S City or Tow | | er or Rural Route Number, |
| Medical Certificati | 29a. Certifier (Check only one) Certifying Physician: To the base and manns | is of axamination and | death occurred at the | a time, date and place, ny opinion, death occur | and dua to tha cred at tha time, c | ause(s) and ma lata and place, a | nnar as stated. and dua to the cause(s) |
| Me Me | 29b. Signature and title of gertifier | // | 29c. Lic | ense number | . : | 29d. Date signed | (Month, Day, Year) |
|) | Muchael & H | -M |) (1 | 11274 | | JAN . | 20,2000 |
|) | 30. Name and address of person who completed cause SILVER M QU | of death (Item 23a) (| Howard | 1 Count | 1 Gene | val C | olumbia, MD |
| State | 31. Data filed (Nonth, Pay, You 1000) 32. Reg | Istrar's Signature | Lagra | 41 | | - | 21044 |

DOOS : SHAL

Transferrack Law

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 12:07 PM A. Haves January 21, 2000 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. Dete MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) February 28, 1951 Washington, D.C. 10 M 20 F Days Months Hours 577-70-5439 48 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Germantown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12450 Milestone Center Drive 20876 United States

Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 TNo Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cerebritis

Nurse

20b. Place of Disposition (Name of cemetery, cremetory or other place)

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line.

ntracramal

Due to (or as a consequence of)

Due to (or as a consequence of):

failure

28b. Time of

"natural", or thems 23a or must be Baltimore, Maryland 21215-0020 Hygiens. permit. Pages 1 and 2 ahould be file Department of Health and Mental Hy important: if item 27 is marked oths any injury or other traumatic event.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show inotified at

Directo

Funeral

by

Judy

10a State

Maryland

1 Never Merried 2 Married

3 ☐ Widowed 4 ☐ Divorced

Box 68760 Division of Vital Records, P.O. certificate

Physician /Medical Examiner Examiner and physician a Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be Certification: To Medical

Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Physician/Medical by 3 Suicide

17. Father's Name (First, Middle, Last) Howard R. Foster 19a. Informant's Name/Reletionship (Type, Print) Carl Hayes - Husband 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 27. Manner of Death 1 Netural 2 Accident 4 ☐ Homicide

25. Was case referred to medical examiner?
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature end title of certifier 31. Date filed (Month, Day, Year)

JAN 2 7 2000

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:

College (1-4or 5+) two years

29c. License number

28c. Injury at Work?

1 Tyes 2 No

D37891

29d. Date signed (Month, Day, Year) January 22, 2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

14. Race - American Indian, Black, White, etc.

Specify:

Private

18 Mother's Name (First Middle Meiden Sumeme)

Adeline Tatum

Lincoln Memorial Cemetery 1/28/2000 Suitland, Maryland

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12450 Milestone Ctr. Drive Germantown, MD 20876

22. Name end Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Wash. D.C. 20019

16b. Kind of Business/Industry

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings svailable prior to completion of cause of death?

1 Yas 2 No

African

Approximate Interval Between Onset and Deeth

American

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ln # 409 Rockville, MD - 20 852

32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death HARRELL 1420 ITRS LINWOOD 20 JAN 2000 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Southern Maryland Hospital Center Prince George's Clinton 6. Sex 1XM 2□ F If Under 1 Year | if Under 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Deta of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Months Deys Hours Min. 246-48-0198 68 Dec.13,1931 Watha, N.C. Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d, inside City Limits Maryland Prince George's Fort Washington 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9010 Cooper Drive 20744 USA 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 1 Vo If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian Black, White, atc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Police Work Secret Service 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Benjamin Franklin Harrell, Sr. Helen Wells 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elvis Harrell/Wife Same as item 10 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Data 20c. Location - City or Town, Stete 1 N Buriei 2 □ Cremetion 3 □ Removel from State Trinity Memorial Gardens 1/24/2000 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Sarvice Licansae 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. ales 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. P.11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on sech line. Approximate intervel Batwean Onset end Death immediate Ceuse (Final disease or condition resulting in death) · VENTRICULAR TACHYCARDIA & FIBRILLATION LATERAL MYOCARDIAL Due to (or es e consequence of): INFARCTION Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest INFERIOR ISCHEMIA POST PERSANTINE STRESS ARTERY DISEASE CURUNARY Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco usa contributa to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION, HYPERLIPIDEMIA 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? PERIPHERAL ARTERIAL DISEASE EXSMOKER completion of cause of deeth? 2 NO 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical exeminer? 26. Pleca of Daeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2X No 27. Megnar of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturei 2 Accident 5 Pending Investigation 1 ☐ Yas 2 ☐ No 3 Suicide 6 Could not be detarmined 28e. Placa of injury - At home, ferm, street, factory, offica building, etc. (Specify)

29c. Licanse number

D46345

by Completed

Examiner Physician/Medical Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

the Maryler

death

7 is marked other than "natural", or itams 23s or 28s-f show traumstic event, the Madical Examinat must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after d Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina-2012.

Physician /Medical

Examiner

physician end the buriel-transit

Box 68760

Division of Vital Records, P.O. i or Attending efter death. Director: Aft To the Hospital or Attar within 24 hours efter der To the Funeral Director completely filled in by th Medical

State

31. Data filed (Month, Day, Year) JAN 2.4 2000

29b. Signeture and title of certifier

Sinivasam

30. Name end eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

4 | Homicida

29a. Certifier

8926 WOODYARD RD #601, CLINTON 32. Registrer's Signeture

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Data signad (Month, Dey, Year)

20/2000

Mb 20735, A. Srinivasan, M.D.

Registrar

JANE 2000 Somme B. March

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| LANKENCE J. BUTTON 1. CONTROL PRISON Name (Prior or installation pin street are managed) 1. CONTROL PRIOR OF CONTROL PRIOR | Physici | an | 1. Decedent's Neme (First, Middle, | | | | | | 2. Date of De Month | Reg. No. eth Dey | Yeer | 3. Time of Deeth |
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| Use of Residence of Decedant P. G. Courty P. G. 10c. Clay Town or Location 10g tasks | | | 5. Social Sacurity Number 220-28-7348 | 6. Sex 1 ☐ M 2 ☐ F | | M | | If Under 24 Hrs. Hours Min. | 8. Data of Bir | th ly Year) 36 | | |
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| Extrest Hutton | | o C | | ast) | | Fiec | ilalite | 18. Mother's Nen | ne (First, Middle, | | | |
| 196. Informent's NermBrieditionship (Type, Print) Hellen Webb / Sister 197. Welling Address (Street and Number or Rural Rock Number, City or Town, Stete, 2g Octob) 4151 Southern Ave, #102, 204. #gts., NA. 20743 206. Method of Disposition of Disposition (Name at August 1975) 198. Informent's NermBrieditionship (Type, Print) 208. Method of Disposition of Disposition (Name at August 1975) 209. Method of Disposition of Disposition (Name at August 1975) 209. Method of Disposition (Name at August 1975) 21. Signatura of Funeric Service Libensee 21. Signatura of Funeric Service Libensee 22. Name and Address (Street and Number or Rural Rock) or Town, Stete Cheletham, Md. 22. Name and Address of Facility (Name at August 1975) 23. Signatura of Funeric Service Libensee 24. Signatura of Funeric Service Libensee 25. Pearl, Enter the disease, or complications that caused the death. Do not arrear the mode of dying, such as cardiac or respiratory errest. Approximate Intervel Between Cheek and Control (Name at August 1975) 25. Pearl (Fine) or death of the Service Libensee or Injury and Control (Name at August 1975) 26. Pearl (Intervel Between Cheek and Control (Name at August 1975) 27. Method of Death (Special) (Name at August 1975) 28. Pines of Death (Special) (Street and Number or Rural Route August 1975) 28. Pines of Death (Special) (Street and Number or Rural Route August 1975) 29. Well (Special) (Street and Number or Rural Route August 1975) 29. Success and Centrol (Special) (Street and Number or Rural Route August 1975) 29. Success and Centrol (Special) (Special) (Street and Number or Rural Route August 1975) 29. Success and Centrol (Special) (S | | To B | Ernest E | Mar | rie Brow | n | | | | | | |
| Security Control Con | | | 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Relationship (Type, Print) | | | | | | | | | |
| 23e Pert. Enter that diseases, or complications that cause and each line. 23e Pert. Enter that diseases, or complications that cause and each line. 23e Pert. Enter that diseases, or complications that cause and each line. 23e Pert. Enter that diseases, or complications that cause and each line. 25e METASTATIC ESOPHAGEAL CANCER Due to (or es e consequence of): 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, if enty, leading to immediate resulting in deelth) Lest 25e Quantially list conditions, leading to immediate resulting in deelth) Lest and place, and Quantially list conditions to consequence of): 25e Quantially list conditions, leading to immediate resulting in deelth) Lest and place and list of cause of leading resulting in deelth) Lest and place and list of cause of leading resulting in deelth) Lest and place and list of cause of leading resulting in deelth) Lest and list of caus | | | MBuriel 2 Cramation | | | cemetery cremetor | remetory or other place) | | | | | |
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| 24e. Wes en eutopsy performed? 24b. Were autopsy finding available prior to completion of cause of deeth? 1 Yes 2 No No Yes Yes No No Yes Yes No Yes Yes No Yes Yes | tached for | hysicia | Pert II. Other significant condition | s contributing to de | eath but not res | sulting In the under | ring cause gi | iven in Pert I. | | | | |
| 25. Wes case referred to medical exeminer? 1 | 9 | è | | | | | | | 24e. Wes en eutopsy 24b. | | 24b. Were | autopsy findings |
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| The state of Deth The state of the state | ptor, p | | | | | | | 28. Pleca of Dee | | | 10 | 765 ZLINO |
| 27. Memrer of Death 1 Neture 29. Detect injury - At home, ferm, street, fectory, offica 28c. Injury et Work? 1 Yes 2 No 28c. Certifier 29c. Signeture and title of certifier 29c. Signeture and title of certifier 29c. Licensa number 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Descri | Ö | 2 | 1 ☐ Yes 2 🖾 No | 101 | | ER/Outpatient 3 | DOA Ot | har | | | ar (Specify) | |
| 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Year) ANUARY 21, 2000 | y the funer | fication: | 1 Neturel 5 Pending 2 Accident investiga 3 Sulcide 6 Could no | tion (Mont | h, Day Year) | Injury & | 1 | | | | | Routa Number |
| Robert G. Wedlerch MD 0031411 JANUARY 21, 2000 | filled in t | | 4 🗆 Homicide | buildi | ng, etc. (Speci | (y) | | | City or Tov | vn, Stete) | | |
| Robert G. Waller MD 0031411 JANUARY 21, 2000 | pletely | | Check only one) Check only one) Control pass of exeminetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. Control pass of exemination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause and manner stated. | | | | | | | | | |
| 30 Name and address of parent who completed again of death (from 22s) (Time Brief) | COO | | | Waller | zh | | | | | | I Calling Control | |
| ROBERT G. WADLEIGH, M.D. 50 IRVING STREET NW, WASHINGTON, DC 20422 | Va | | | | | | | | | | | |

in share

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 2000 5:30PM Elmer Lee Hilliard January /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□M 2K)F 89 May 11, 1910 Louisiana Director 073-20-1706 Usuel Residence of Decedent the Maryland 10a State 10b, County 10c. City, Town or Location ahow 10d. Inside City Limits "natural", or items 23s or 26s-f show 1 XYes 2 No Maryland Prince George's Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stewart Lane 20735 United States death 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black. Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than ". Elementery/Secondery (0-12) College (1-4or 5+) Private 12th Nurses Aide 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Unknown Unknown 19a. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Heelth a if item 27 is or other trai 7322 Donnell Place, #B-7; Forestville, MD Willie Johnson, Jr. - Nephew 20747 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 1/25/2000 Clinton, MD 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 eway . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart feiture. List only one cause on sech line. Approximate Intervel Between Onset and Deeth **Physician** /Medical SEPTIC SHOCK Immediate Cause (Final 1 DAY disease or condition resulting in deeth) Examiner Examiner L DAY IROSEPSIS ician and burlai-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last Due to (or as a consequence of) physician as the burial Box 68760. Physician/Medicai Due to (or es a consequenca of): signed by the a d be detached f P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably ♦ Unknown Hemiplegia AND Appasia Records. þ 24b. Were autopsy findings available prior to Completed Atrial Fibrillation. 24a. Was an autopsy performed? completion of cause of death? Receirrent UROSEPSIS 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? or Attanding Physician: Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Netural after deeth. Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital of 24 hours at a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier edical completely (Check only one) within 2 9 29b. Signeture end title-of-certifier 29c. License number 29d. Date signed (Month, Day, Year) Jurana JANUARY-19-2000 D 50653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN CHAND SURAMA 5851 DEALE CHURCHTON DEALE RUAD 31. Date filed (Month, Day, Year)

JAN 2 4 2000 32. Registrer's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

| : | | 10 1 11 11 | | | ar yrar i | | Certificate | | | | Reg. No. | 0 0 | 14116 | |
|--|------------------|--|--|---|-----------------------------|--|---|------------------------|-----------------------------------|-----------------------------------|-----------------------------------|---------------------------|--|--|
| Physici | an | 1. Decedent's Nama (i | | 80) | | | | | | 2. Date of De Month JANUAR | Dev | Yeer 000 | 3. Time of Death 9:25am | |
| /Medic Examin | | 4e Facility Neme (If no | ot institution, give | street end number) | | | | 4b. C | ity, Town, or Lo | | | | J. ZJalii | |
| Funeral Director | | SOUTHERN 5. Social Security Num 086-30-256 | ber 6. S | D HOSPITAI ex 7. Ag | ge (In yrs. I | ast birtho | Months Da | er If | Under 24 Hrs. lours Min. | 8. Dete of Bi | PRINC | 9. Birtho | RGES place (State or Foreign HINGTON D. (| |
| yland | | Usual Residence of De 10a. Stete 1 | ob. County | | 10c. City | , Town o | or Location | | | 10d. Inside City Limi | | | | |
| death with the Manyland ms 23a or 28a-f show | ctor | MD. F | RINCE G | EORGES | FOR | ESTV | ILLE | | | | | | 1 ∑Yes 2 □ No | |
| Vith th | Funeral Director | 10e. Street and Number | | | | | 10f. Zip Cod | | | | 10g. Citizen of 1 | What Coun | try? | |
| eath v | erai | 7420 MALBOF | RO PIKE | 12. Was Decedent | Ever in U.S | 3 | 2074 | | nic Origin? (So | acity Yes or No | U.S.A. | e - Americ | en Indien. | |
| U2U urs after death with the Manylar af, or Neme 23a or 28a-f show Engine mast be notified at | by | 1⊠ Nevar Married 3 □ Widowed 4 [| | Armed Forces? 1. Yes 2 ☐ If Yas, Giva Yaar or Datas: | | | 13. Wes Decedent of Yes, specify C | | lexican, Puerto pecify: | Rican, atc.) | Specif | ck, Whita, | | |
| d 21215-0020 filed within 72 hours after Hygiene: ither than "natural", or Ne ant, re-Medical Exercities | Be Completed | (Specify Elementary/Seconds 11th grade | i. Decedent's Ed only highest gre ary (0-12) | ucetion de completed) College (1-4or | 5+) | 16a. Decedent's Usuel Occupation (Give kind of work done during most of workin life. DO NOT use retired) CHAUFFER | | | | | 16b. Kind of B | | | |
| be filed tell Hyging d other evant, T | ပိ | 17. Fathar's Name (Fin | | | | CHA | OFFER | 18. | Mother's Neme | e (First, Middle | , Maiden Sumen | | OSIKI | |
| should be filed and Mentel Hygi marked other umatic evant, | To B | UNKNOWN | | | | | | | INEZ JOI | NES | | | | |
| Md 2 dd 2 | | 19e. Informant's Neme LEROY CLAY | | | | | Meiling Address <i>(Str</i> 6 5th ST | | | | er, City or Town, | State, Zip | Code) | |
| altimore, mit. Pages 1 an partment of Heal portant: if New 2 y Injury or other | | 20e. Method of Dispos 1 Derived 2006 4 Donetion 5 [| ramation 3 🗆 | Removel from State | CHE | ece of D | isposition (Name of arematory of EMA | rior | | Dete 29/00 | 20c. Location - BELTSV | | | |
| permit. Par Department Important: any Injury Ditte. | | 21. Signeture of Funar | rel Service Licen | see | 200 | | 22. Nama end Ad 716 KENN | | , 101 | | | S FUN | ERAL HOME | |
| hysician be associated by the purish transit as the burial-transit | ai Examiner | Immediate Cause (Fin disease or condition resulting in death) Sequentially list condit if eny, leeding to imme cause. Enter Underlyi Cause (Disease or Inju- | | b | Car | 110 | requence of): | le. | Hypor ock | tensi | m | /2 | Onset end Death Ohrs. 2 his. | |
| DOX 08/00, seth certificate be avaited physician for use as the burie | n/Medicai | thet initieted events resulting in deeth) Las | | d | Due to (or | or es a consequence of): | | | | | | | | |
| death cert | Physician/M | Part II. Other significa | nt conditions co | | | | | | | tobacco use co | gtributa to | the cause of death? | | |
| IS, T.O. BOX of the standing be detached for use as | by Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Septic Shock syndrme, Spangery | | | | | | | | | 1 Yes 2 No 3 Probably 4 Unit | | | |
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| ysician: The | o Be | 25. Wes case referred axeminer? 1 ☐ Yes 2 ☐ No | | Hospitel: | , a D E | - P/Oute | ations 20 DOA | Other | Place of Deetl | | | or /Consider | L.1 | |
| MISTOFI OF VIEW Attending Physician: or death. octor: After this certific by the funeral director, | - | 27. Menner of Death | investigation | 28e. Dete of Inju (Month, De | iry | 28b. Tim Inju | | njury at Work? | | | idence 6 Oth how injury occur | | 0 | |
| 2 5 4 5 5 | Certification: | | Could not be determined | 28e. Piece of Inj building, et | ury - At hor c. (Specify | me, farm | , street, fectory, offi | ice | | | (Street end Numb wn, Stete) | ber or Rura | l Route Number. | |
| n 24 hours a n 24 hours a ne Funeral D | edical (| 29e. Certifier 12 (Check only 20 one) | Certifying Phy Medical Exam | raician: To the best iner: On the basis o end menner st | l examineti | rledge, d on and/o | eeth occurred et the r investigetion, in m | e time, d ny opinio | ate and place, n, deeth occurr | and due to the ed at the time, | cause(s) and m date and place, | annar as si and due to | ated. the cause(s) | |
| To the within 2 To the comple | Σ | 29b. Signeture end title | of cartifier | | | | 29c. Lic | ensa nu | mber | | 29d. Dete signe | d (Month, | Day, Year) | |
| (2) | | 30. Name and address | ord (4.7) | WYSIN, / | MD leath (Item | 23a) (Ty | pe, Print) | 00: | 223- | 7 | , | | -00 | |
| Sta | te. | 31. Data filed (North) | | m, MD) | | | 1d. Forth | ld. | tt. Wa | ish, Y | nd 2 | 0740 | 1 | |
| Registra | ar | JAN Z | <i>t</i> 2000 | Sepus | - | A | don of | , | | | | | | |

DHMH 16 Ray 6/95

JAN 2 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 1 **Physician** 24 2000 CHARLES JONES, SR. 8:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10900 BELL ROAD LANHAM PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth January 8, 1915 9. Birthplace (State or Foreign **Funeral** Months Days 10XM 20 F Hours Maryland 85 579-20-2294 Yrs. Director Usual Residence of Decedent the Mantand 10s State 10b Counts 10c. City, Town or Location 10d. Inside City Limits must be notified. 1 X Yes 2 No Director Maryland | Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 報 flerns 23a 10900 Bell Road 20706 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Merital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2X No Specify: Specify. P **Black** 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Other then "n Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be parmit. Pages 1 and 2 should be i Department of Health and Mental i important: If Item 27 is merked of any Injury or other traumatic eve Charles Henry Jones Viola Jackson 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma T. Chittams/Daughter 7742 Bender Road, Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 01/28 2000 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removet from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signeture of Funerel Service Licenses J. Name and Address of Fecility
J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) TERMINAL CANCER OF COLON ONE YEAR Examiner Due to (or es e consequence of): Physician/Medical Examiner physician and the burial-transit that the death certificate be assouted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es a consequence of): USB Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? o signed by the 1 Yes 2 No 3 Probably 4 Unknown 0 CANCER OF PROSTATE þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? paga 2 1□ Yes 2 No 1 Tyes 2 No or Attanding Physician: 8 25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 8 ☐ Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 X Neturat 5 Pending investigation 1 Tes 2 No death. 124 hours after death the Funeral Director: A pletaly filled in by the f 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Records, Division of Vitai Hospital

To the Hosp within 24 ho To the Fune completely fi

State Registrar

Medical

29e. Certifier

(Check only one)

29b. Signeture and title of certifier

JAN 2 8 2000

EN M.D. 8824

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cicininglan Drive, Borny Hayles, md 20940

11 critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death | Reg. 1 | No. | 7110 |
|---|--|---|--|--|
| The state of the state of | Decedent's Name (First, Middle, Last) | 2. Date of Death | | 3. Time of Death |
| Physician | Smithly Cleo Jones | January | 23,2000 | 1:28PM |
| /Medical Examiner | 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo | - | 4c. County of Death | 7 |
| - Kerminer | Southern Maryland Hospital Clinto | | | Coorana |
| Formani | Southern Maryland Hospital Clinto Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8 Date of Birth | Prince (| |
| Funeral Director | 177-36-5647 1 M 20XF 55 Yrs. Months Days Hours Min. | (Month, Dey, Yea | 944 N. | place (State or Foreign ntry) C • |
| anyland ahow | 10a. State 10b. County 10c. City, Town or Location | | 0d. Inside City Limits 1 XYes 2 No | |
| or 28e-f a | MD. Prince Georges Clinton | | | |
| Olr Olr | 10e. Street and Number 10f. Zip Code | 109. | Citizen of What Cour | ntry? |
| 4 23 F | 9321 Pella Place 20735 | U | nited St | ates |
| 72 hours after death with the Maryland 72 hours after death with the Maryland natural; or thems 23e or 28e-f ahow alca Esamber mast be notified at sted by Funeral Director | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces □ U,S. Armed Forces □ U,S. Armed Forces □ U,S. If Yes, specify Cuban, Mexican, Puerlo 1 □ Yes 2 □ No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Americ Black, White, Specify: | elc. |
| 72 hours at netural, or pice Lean | | 1 | B1a | |
| 72 h | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | ing 16b. | . Kind of Business/In | dustry |
| hould be filed within 72 hours hould be filed within 72 hours marked other than "natural", matic event, ma marical To Be Completed by | Elementary/Secondary (0-12) College (1-4or 5+) 4 Supervisor | | EBI | |
| d 2 should be file th and Mental Hy T is marked oth traumatic event | 17. Father's Name (First, Middle, Last) 18. Mother's Name | e (First, Middle, Maid | len Sumame) | |
| 2 should be for and Mental Planarked or reumatic eve | William Graham Bertha | Hardy | | |
| ode Maria | | | ty or Town, State, Zip | Code) |
| and 2 | 19a. Informant's Name/Relationship (Type, Print) Clinton Jones/husband 19b. Mailing Address (Street and Number or Run 9321 Pella Place Clinton, MD. 20735 | | | |
| a 1 and 2 should be filed. I hash and Mental Hyd Iden 27 is marked other other traumatic event, | 20a. Method of Disposition 20b. Place of Disposition (Name of | | Location - City or To | |
| 25- | 1 XRuriel 2 Cremetion 3 CRemoval from State cemetery, crematory or other place) | | | |
| nit. Pa antman ortant: Injury | | 1/30/09 _{Ma} | | |
| pemit. Page Department of Important: If any injury or pnos. | 21. Signature of Funeral Service Licenses 22. Name and Address of Facility | lodges & | Edwards | F.H. |
| 20539 | Jenny Holles 3910 Silver Hill | PD Sui | t land | MD. 2074 |
| Wedical Examiner Adical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Multiplication Culton C | ances. | | entero - d |
| \$ 9 ª Z | Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. Ohl ma | | | allow of |
| de de | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobac | co use contributs to | the cause of death |
| | Hyper ruthinio | 1 🗆 Yss | 2□ No 3□ Pro | bebly 4 Upknow |
| \$ 50 G | | 24a. Was an au performed | ? av | ere autopsy findings allable prior to impletion of cause death? |
| F # Z O | | 1 ☐ Yes | 25(No 16 | Yes 2□ No |
| certificata rector, pag | 25. Was case referred to medical 26. Place of Death | h (Check only one) | | |
| | examiner? A Hospital: Other | me 5 Residence | 6 Other (Specific | (v) |
| or Attending Physical or Attending Physical Director: After this of in by the funeral of ertification: To | | 28d. Describe how in | | , |
| na for Attending P or affector: Affect and in by the funer Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street City or Town, St | t and Number or Rura tate) | al Route Number, |
| To the Hospital or A within 24 hours after To the Funeral Dire completaly filled in D Medical Certi | 29a. Certifier (Check only Check on C | and due to the cause red at the time, dete | e(s) end manner as s end place, and due to | tated. the cause(s) |
| N Some | 29b. Signature and title of certifier 29c. License number | 29d. | Date signed (Month, | Day, Year) |
| | Mary do . 1 DEALITH | - | | 1.3 |
| (17) | 030737 | 3 1 9 2 3 | 1000 | 422000 |
| (1) | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREST 1916 TRAS 9801 19001 | SIA BU | e-#3- | 35 |
| State Registrar | 31. Date filed (Month, Duy, Your JAN 2 7 200) 32. Registrar's Signature SIIVER SPIE, | INS, M | 10900 | _ |

JAN 2 7 2000 Same & Janes

Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death 2. Data of Death Month 5:30am CHARLES E. JONES JR. January 17, 2000 4a Fecility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death BIRCHWOOD NURSING HOME ACCOKEEK PRINCE GOERGES 5. Sociel Security Number If Under 1 Year If Undar 24 Hrs 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foreign Country) 6. Dete of Birth (Month, Dey, Year) Min. 15 M 2□ F Months Deys Hours 75 579-22-5209 April 13,1924 Wash. D.C. Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 716 Decatur St., N.W. 20011 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Dates: 43-46 1 Never Married 2 Marr 3 Widowed 4 Divorced 2□ Married 1 Yas 2 No Specify: Specify: Black. 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Collega (1-4or 5+) 12th Printer Government 17. Fathar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) Charles E. Jones Sr. Mable Hines 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Stacey Collins/Daughter 1940 Lebanon St., Hyattsville, Md. 20783 20b. Pleca of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1X Burial 2 Cremation 3 Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Marylands Veterans Cem 1/25/00 Cheltenham, Md. 22. Name end Address of Facility Johnson & Jenkins Inc. 21. Signature of Funaral Sarvice Licansee 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disaesa, or complications thei caused the death. Do not entar the mode of dying, such es cardiac or respiretory arrest, shock, or heert failura. List only one causa on aach lina. Approximata Intarval Between Onset and Death Immediate Cause (Finel disaasa or condition resulting in deeth) PRRHWTH MAA Dua to (or as a consequence of): HEART FALLURE COYGESTIVE PARETES MELLITUS Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yas 2 No

Physician /Medical Examiner

attending physicien and for use es the burial-transit

signed by the

page 2

8

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pelli

Be

Certification: To

Medical

f or Attending Physician: after death. Director: After this certifica

To the Hospital of within 24 hours a To the Funeral D

that the death certificate be executed

Box 68760.

P.O.

Records.

of Vital

Division

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Нетя 23е

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiens. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Wed call Examinations.

the

death

21215-0020

Baltimore, Maryland

Director

Funeral

þ

Completed

Be

D.C.

Examiner Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical þ Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I.

25. Was case referred to medical examinar? Hospital: 1 Yes 2€ No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 5 Pending investigetion

28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. injury at Work? 1 Yes 2 No

Other: 45 Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) 28d. Dascribe how injury occurred

26. Placa of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifiar

1 Netural

2 Accidant

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licensa number 1)16094 29d. Deta signed (Month, Day, Year) 2000

30. Name and address of p foliated cause of death (Item 23a) (Type, Print)

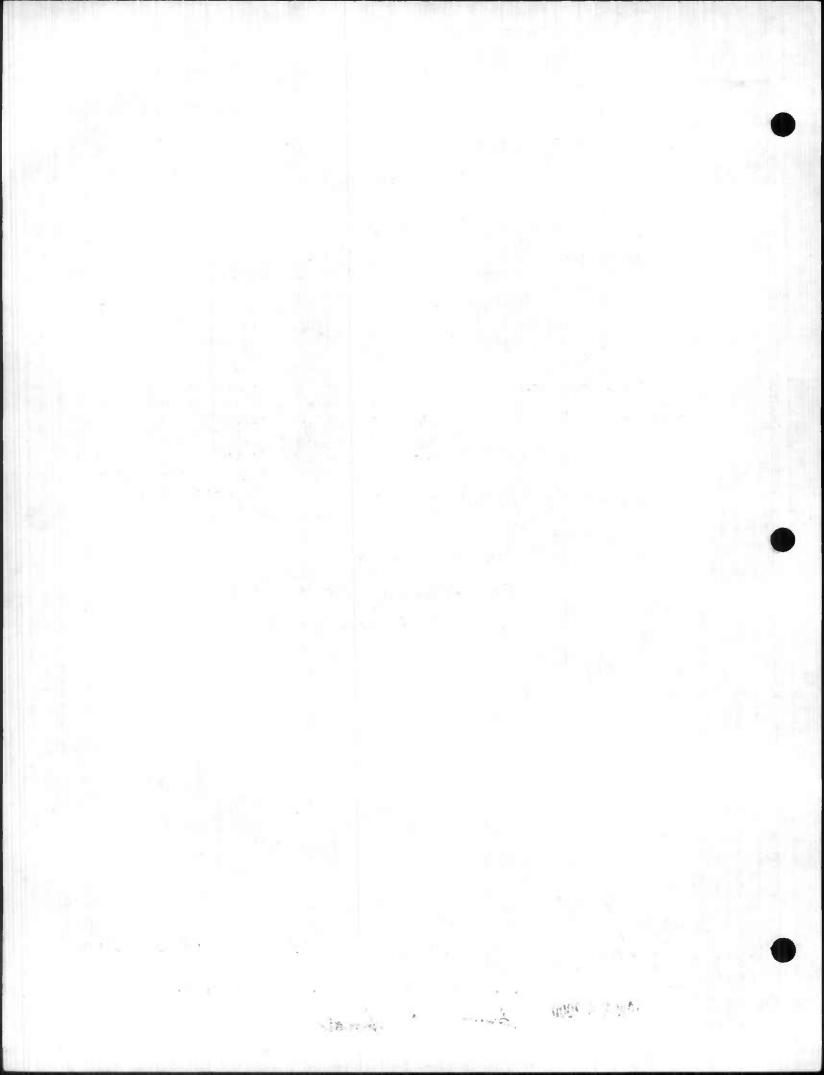
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Oxon Hill Rd. Oxon Hill, MD. M.D. 6130 20745

State Registrar

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Please Type or Print in Black Indeiible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day 8:44 P.M. **Physician** Mary Eliza Johnson
4a Facility Nama (If not Institution, give street and number) 01/18/2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cheverly, MD Prince Georges Hospital If Undar 1 Yeer If Undar 24 Hrs. Hours | Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funeral** 10M 30F Months Davs Charlottsville 87 Yrs. Director 577-24-9755 Usual Rasidance of Dacedani the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28a-f show other traumetic event, the Medical Examines must be notified at Yas 2□ No Director MD P.G. Forestville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20747 USA 1309 Ashville Road Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Datas: 13. Was Dacedent of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black Whita, atc. i and 2 should be filed within 72 hours after of Health and Mentel Hygiena. 1 ☐ Navar Married 2 ☐ Married 1 Yes X No Specify: becity: 3□ Widowed 4□ Divorced Black by Completed Decedant's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedant's Education (Specify only highest grade completed) Etamantary/Secondary (0-12) Cotlega (1-4or 5+) Food Service Raker 8th 18. Mothar's Nama (First, Middle, Melden Surname) 17. Fathar's Nema (First, Middle, Last) Be (Unknown) Charles Craighead 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) permit. Peges 1 and 2 to Depertment of Health ar Important: If item 27 ls. any Injury or other trau 1309 Ashville Road, Forestvills, MD 20747 Calvin Johnson Baltimore, 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State Donetion 5 Other (Specify) Glenwood Cemetery Jan. 24 Wash., D. C. 21. Signature of Funeral Service Licensea 22. Nama and Address of Facility James E. Vann Funeral Home 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** Possible Myocardial infarction /Medical Immediata Causa (Finat disease or condition resulting in death) Examiner Examiner physician and the buriel-trans Sequentially list conditions, if eny, laeding to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): requires that the death certificate be exec Box 68760 Physician/Medical Dua to (or es a consequenca of): use as 1 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? ed by the a Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 ₩hknown Hypertension signed b g 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed Diabeter 1 Yes 2 No 1 ☐ Yes 2 TNo certificate or Attending Physician: 25. Was casa rafarred to medical Be 26. Placa of Death (Check only one) axaminar? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funeral 28e. Deta of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Natural 5 Pending efter deeth. Director: Aft 1 Yes 2 No invastigation 2 Accident 6 Could not be detarmined 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funerel Di complataly filled in 1 Cartifying Physician: To the best of my knowledga, deeth occurred at the time, data and placa, and dua to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura end title of certifiar 29c. License number D43446 30. Name end eddrass of person who completed cause of death (Item 23a) (Type, Print) 20902 9801 Georgia ave. Suite 3-35 SILVER SPRING MO ROINTAN FARA
31. Dete filad (Month, Day, Year)
JAN 2 7 2000 FARAHIFAR 32. Registrar's Signetura Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 23, 2000 **Physician** KATHERINE J. 2:35PM KORNEGAY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12213 Wheeling Avenue Upper Marlboro Prince George's If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth Month Day, Year) May 19, 1933 5. Social Security Number 9. Birthplace (State or Foreign N. Carolina 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 M 2 T 66 238-46-6235 Yrs Director Usual Residence of Decedent the Mandand 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George"s Upper Marlboro 1X Yes 2 No MD Director 28e-f 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 2 12213 Wheeling Avenue 23a 20772 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 1 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. 72 hours after 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Social Worker State Government permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyge important: If item 27 is marked any injury or other. Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Clifton Jones Hattie Bruce 19e. Interment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Tammy T. Anderson - Daughter 12213 Wheeling Avenue; Upper Marlboro, MD 20772 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from Stete Fort Lincoln Cemetery 1/28/00 Brentwood, Maryland 4 Donetion 5 Other (Specify) 21. Signature of 22. Name end Address of Fecility
Robert O. Freeman Funeral Services, Inc. 1353 H Street, N.E.; Washington, DC 20002 finite the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, at hear teilure. List only one yause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ears Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 1 Tyes 2 No Attending Physician: funeral director. 89 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) HOSPICE Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No Investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier Sompletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and the of certifier Houlde MO D46704 2000 KAISER PERMANENTE 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) KAN KON DE 4 UTO MBO 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State JAN 2 7 2000

DHMH 16 Rev 6/95

Registrar

Pie

| | Pleas | se Type or Pri | nt in Blac | | | | | • | _ | ible. | 04122 |
|--|---|--|----------------------------|--------------------|---|----------------|--|---|------------------|------------------------------------|--|
| | | | ,, . | | tificate of | | | | g. No. | JU | 04166 |
| 1. Decedant's Na | ma (First, Middla, FLEU | | KRUG | | | | | Data of Death Month | 3 | Yaar | 3. Tima of Death 7:45 PM |
| | | giva streat and number | OME | | | 4b. City, Tov | wn, or Location | | 4c. County | y of Death | |
| 5. Social Sacurity 212-03- | -7773 | 6. Sax 7. A 1□ M 2 □ F | ga (In yrs. last bii 87 | thday) Yrs. | If Undar 1 Yaar Months Days | | | Data of Birth Month, Day, N • I U | Year) 1913 | 9. Births Cour MAR | placa (Stata or Foreign |
| Usual Rasidanca 10a. Stata MD • | 10b. County | GOMERY | 10c. City, Tow | | cation CKVILL | E | | | - | 1 | 0d. Insida City Limits 1X Yas 2 No |
| 10e. Straat and N 9701 | umber - VEIR | S DRIVE | | | 10f. Zip Coda 20 | 850 | | 10 | g. Citizen of US | | ntry? |
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| 21. Signature of F | unaral Sarvi | ousee A. | | H | Nama and Addr YSONG 300- N | CO., I | NC. | INCU | DC | | 34 |
| 23a. Part1. Enter shock, or ha | art failura. List of | omp cations that cause nly cre cause on each I | na. | not anta | r tha moda of dy | ing, such as c | cardiac or ras | spiratory arras | St, | | Approximata Intarval Batween Onsat and Death |
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| Sequantially list configuration in any, leading to increase. Enter Und Cause (Disease othat initiated evantrasulting in death) | mmadiata larlylng or injury ts | c. Arles | Dua to (or as a c | es d | lanca of): | 1 | Vascu | lar d | Isem | | suzears |
| 0 0 | 1 | d. | 1 | | .// | van in Part I. | | 23b. Did tob | | | the cause of death? |
| | | noli He | | | | ace n | uahes | 24a. Was an | autopsy ed? | ava | ara autopsy findings allabla prior to appletion of causa |

Physician /Medicai Examiner

To the Hospital or Attending Physician: The law requires thet the death certificete be axecuted within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completaly filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Funeral Director

Completed by

Be

10

Examiner

by Physician/Medical

Be Completed

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Certification:

Medical

Funerai

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Haath and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Macterial Examples must be notified at angles.

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or injury that initiated evants rasulting in daath) Last

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of death?

1 🗆 Yas 26. Placa of Death (Check only ona)

1 Yas 2 No

| 25. | axaminar? | |
|-----|-----------------|--|
| | 1 Yas 2 No | |
| 27. | Mannar of Death | |

1 Natural 5 Panding invastigation

1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartiflat (Check only

2 Accidant

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certified

29c. Licansa number

29d. Data signed (Month, Day, Year)

run 30. Nama and address of parson who complated causa of daath (itam 23a) (Type, Print)

9701- VEIRS DR., ROCKVILLE, MD. SCHEMM-C.

State Registrar

31. Data filed (Month, Day, Year)

JAN 2 8 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Physician | 1. Decedent's Neme (| First, Middle, Last |) | | Certificate of | | 2. Dete of Dec | | | 3. Time of Deeth |
|---|---|--|--|--|--|--|--|---|--|--|
| | John | A. Kin | rwan | | | | Month January | Dey 20, 2 | Yeer | 4:00 A.M. |
| /Medical Examiner | 4e Fecility Name (If no | ot Institution, give | street end number) | | | 4b. City, Town, or L | | | | 7.00 11111 |
| LAGIIIII | Doctors' | Communi | ty Hospita | al | | Lanham | | Princ | e Geo | rge's |
| uneral | 5. Social Security Num | | | e (In yrs. last b | Months Dev | | 8. Date of Birt (Month, Da | h v. Year) | 9. Birthple | ce (State or Foreign |
| irector | 172-40-89 | | 1M 2□ F | 51 | Yrs. | | | | | sylvania_ |
| > | Usuel Residence of De 10a. Stete 1 | ecedent 0b. County | | 10c. City. Toy | vn or Location | | | | | d. Inside City Limits |
| aho or | | Prince G | eorge's | | nbelt | | | | 1.0 | 1,□Yes 2□No |
| 23a or 28a-l ahow uni be rolli'nd al rai Director | 10e. Street and Numb | | | 0100 | 10f. Zip Code | a . | | 10g. Citizen of ¹ | What Countr | ΛΛ |
| DI | 7836 Jaco | | | | | | | | | |
| iner must iner must Funeral | 11. Meritel Stetus | DS DIIVE | 12. Wes Decedent E | Ever in U,S. | 207 | / U of Hispenic Origin? (Sp uban, Mexican, Puerto | pecify Yes or No- | United 14. Rec | e - America | n tndien, |
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| 0 | 3 ☐ Widowed 4 I | □Divorced | If Yes, Give Yeer or Dates: | 66-70 | 1□ Yes 2□1 | lo Specify: | | Specif | Whit | e |
| r, the Madical | | 5. Decedent's Edu only highest grad | | 166 | Decedent's Usuel Oct (Give kind of work do life. DO NOT use ref | cupetion ne during most of won | kina | 16b. Kind ot B | uslness/Indu | stry |
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| rent | Michele M | | | 19 | 7836 Jacob | | | | | |
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| any injury | . 1 | | | | Pohort F | Franc Fu | neral Ho | ome, Ind | · . | |
| | 23a. Part. Enter the | dispasa or narra | lications that caused | the death Do | 16000 Ann | napolis Rd | . Bowie | Marylar | nd 207 | 15 Approximete |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Lest) 2. Data of Death 3. Time of Death Day 9:25 AM Month Year **Physician** Rita JANJARY 26 2,000 Kwapinski /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Doctors Community Hospital Prince Georges Lanham ff Under 24 Hrs. If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 30XF Months Days Hours 77 067-12-0633 Director July 14 1922 New York Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-1 show Examiner must be nothled at 1 Yas 2 No Director Maryland Prince Georges Seabrook 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5600 Linwood Ct. U.S.A. 14. Race -Funeral 20706 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Nevar Merriad 2 Married natural, or 1 ☐ Yas 2 ☒ No Specity: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Semit. Pages 1 and 2 should be filed wil be programed of Health and Mental Hygiene Important: If item 27 is marked other than any holiury or other treumatic event, that backs. Cashier Royal Farms 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Rocco Treppiedi Anna DiLullo 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Martin E. Kwapinski (Son) 5600 Linwood Ct. Seabrook, MD 20706 Baltimore, 20b. Place of Disposition (Nema of cematary, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 Donation 5 □Othar (Specify) Quantico Nat'l Cemetery 1/31/00 Triangle, Virginia 21. Signature of Funeral Seprice Licenses 22. Nama and Address of Facility Rendon/Hale Funeral Home 9013 Annapolios Rd. Lamnham, MD 20706 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in death) **Examiner** Examine hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Alvola Heart nices Physician/Medical Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown by Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 1 ∏ Yas 2 ∏ No or Attending Physicien: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Natural 5 Pending invastigation 24 hours after death. 1 ∏Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated. Medical Example: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. To the Hospi within 24 hours To the Funer Completely fil 29a. Certifiar 29b. Signetur e d titla of our 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

DHMH 16 Rav 6/95

Box 68760,

P.O. P

Records,

Division of Vital

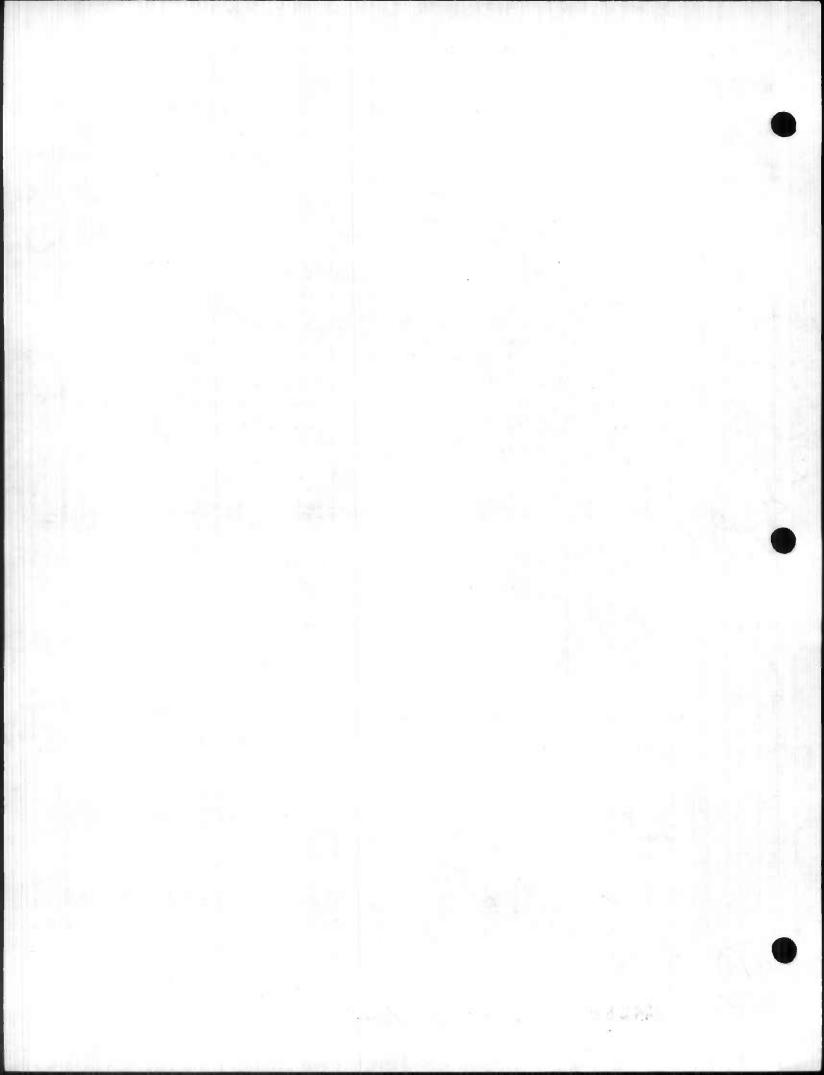
JAN 2 8 2000

32. Registrar's Signature

eted causa of death (Item 23a) (Type Print)

ORIGINAL

for 11 Jugar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dav Theresa Lee Irma 22, 2000 4:45AM January 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Death Prince George's General Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth Novin, Day Year 928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2XF Months Days Hours Min. Yrs. 579-30-7405 New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 20No Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number U.S.A. 20735 6201 Woodland Lane 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Rece - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritai Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th Fiscal Clerk State Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) William E. Nikodem Elizabeth Bolka 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert H. Lee, Jr. (Son) 2202 Snoqualmie Layton UT 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 26 Jan. Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) 2000 Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry RD Clinton, MD 20735 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in deeth) Sequentially ilst conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last netas 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 No 1 Tyes 2N No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No Investigetion

that the death certificate be axecuted physician end the burial-transit Division of Vital Records, P.O. Box 68760, SB esn signed by the a d be detached for page 2 certificate funeral director, After this

Physician/Medicai p Completed Certification: To

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Dey, Year)

JAN 2 7 2000

Examiner or Attending Physician: after death. filled in by

Physician

/Medical

Examiner

Directo

Funerai

by

Completed

Be

Funeral

Director

with the Maryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiena. I important: if item 27 is marked other than "naturel", or itema 23a or i eny injury or other traumatic event, the Medical Examiner must be nonce.

Physician /Medical

Examiner

3altimore, Maryland 21215-0020

24 hours a Funeral C edicai To the Hosp within 24 ho To the Fune completaly fi

Hospital

29b. Signature and/fitte of cartifian

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the cause(s) and manner as stated.
2 Medical Examiner; On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29d, Dete signed (Month, Dev. Year)

00

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALTOS

32. Registrar's Signeture

Cheverly

Registrar

124 67 2000 Same

of the same of the same of

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| Funeral Director | 1 | Social Security Nur. 44-26-009 Isuel Residence of D | 00 | oex 1□M 2\tilde{\tilie}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}} | Age (In yrs. le 68 | Yrs. | Months Deys | | Min. | 8. Data of Birth (Month, Day July 23 | , 1931 | Penns | ace (Steta or lry) sylvani | ia_ |
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| or 2 | 1 | 0e. Street end Numb | ber | | | | 10f. Zip Code | | | 1 | 0g. Citizan of V | What Coun | try? | |
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| of the state | | 0e. Method of Dispo | sition | | 20b. Ple | ece of Dispos | sition (Name of setory or other pl | aca) | | Data | 20c. Location - | City or To | wn, Steta | |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Edith JAN 22 sox 9:12 AM M . Lucas /Medical 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 10 M 20 F 52 Yrs. 579-64-5187 Director Jan.19,1948 WVA **Usual Residence of Decedent** the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits ehow r than "natural", or Nems 23s or 28s-f short the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD PG Oxon Hill XXXX 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 2146 Alice Avenue #101 20745 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after not of Heelin and Mental Hygione.

Int. If Rem 27 is marked other than "natural; or Neury or other traumatic avent, the Marian Institution of the programment of the Marian Institution of the Marian In 1 ☐ Yes _2 ☐ No If Yes, Give X 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes X 2 ☐ No Specify: Specify 1 ack þ 3 ₩ Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Domestic Elementary/Secondary (0-12) College (1-4or 5+) Housewife 9th Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William Moore Sr. John Irene Kelly 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 4 5 19a. Informent's Neme/Reletionship (Type, Print) Theresa Brown- sister-in-law 2146 Alice Oxon H111, Md 20c. Location - City or Town, Stete Avenue 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 3 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or page. Harmony Memorial 1/29/00 Landover, MD. 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility WFMagruder 2311 MLK Jr., Ave.SE WDC 20020 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner sician and burial-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, physician s the burial SSION Physician/Medical Due to (or es a consequence of) 82 080 signed by the at id be detached fo P.O. Pertifi. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? should Be Completed has page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physicien: director, 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1□ Yes 2D No Certification: To After this funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Tima of 28c. fnjury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 30. Hame and address of person who campleted cause of death (Item 23a) (Type, Print) hRAM

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 2000

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Registrar'a Signeture

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month JANUARY 25, 2000 tion of Death 4c. County of Death LINDA ELIZABETH LYWCH 06:40 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 27, 1948 Pennsylvania 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🛛 F 201-38-5636 Yrs. 51 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Greenbelt 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11-G Hillside Road 20770 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Department Elementary/Secondery (0-12) 12 College (1-4or 5+) of Agriculture Research Cook 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Matthew J. McGovern Mary Elizabeth Boehm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Lynch - Husband 11-G Hillside Road, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☑ Removal from State North Side Cemetery 1/31/00 Pittsburg, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home 21. Signature of Funeral Service Licensee Dasc tle 4739 Baltimore Avenue, Hyattsville, MD 20781 OX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2) No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy a No 1 Yes 20110 1 ☐ Yes 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigefion, in my opinion, death occurred of the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one)

Records, Division of Vital al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, pa 24 hours

P.O. Box 68760,

To the Hosp within 24 ho To the Fund completely f

DHMH 16 Rev 6/95

filled in

State Registrar

Physician

/Medical

Examiner

Director

Funeral

Funeral

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Sermit. Pages 1 and 2 should be l Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve

Physician

/Medical Examiner

been signed be should be det

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Certification: To

Medical

Baltimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year)

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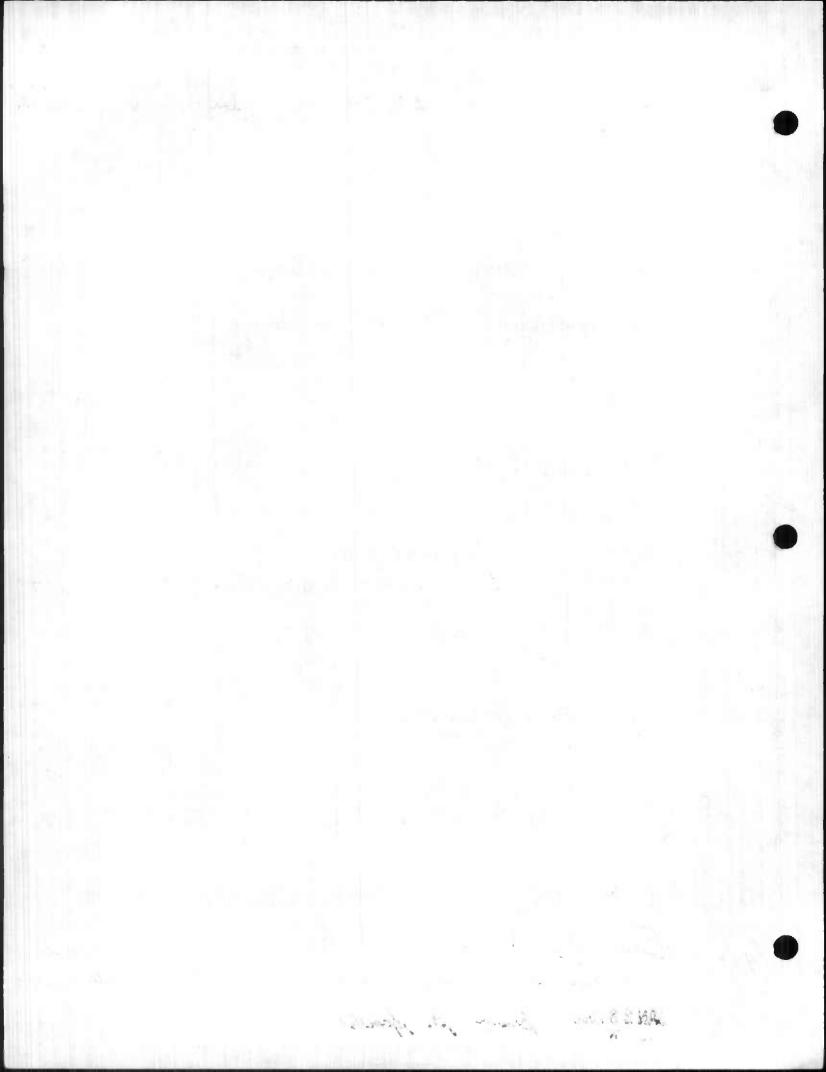
32. Registrar's Signature

who completed ceuse of death (Item 23a) (Type, Print)

29c. License number

7525 Greenway Center Drive, Suite 202, Greenself, MD 20770

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

| | | | Cert | ficate of | Death | Reg | g. No. | 0 0 | 14163 |
|--|--|--|--------------------------------------|---------------------------------------|--|--|------------------------------------|--------------------------------|--|
| Physician /Medical | Decedent's Name (First, Middle, Last) JULIA | | MERRI | тт | | 2. Date of Death Month JANUAR | | Year | 2:46 am |
| Examiner | 4e Facility Name (If not institution, give s | | | | | Location of Death | 4c. County of | of Death | |
| | SOUTHERN MAR | | | If Under 1 Year | CLINTON If Under 24 Hrs | | PRINC | | |
| Funeral Director | 378-34-8109 | 7. Age (In yrs. | | Months Days | Hours Min | | 1920 | CUBA | e (State or Foreign |
| D 2 22 | Usual Residence of Decedent 10a. Stete 10b. County | 10c. Cit | y, Town or Loca | tion | | | | 10d. | Inside City Limits |
| the Maryl 2se-f sho notified a | MD PRINCE G | EORGES CI | LINTON | | | | | | 1 Yes 2 No |
| vim the Ma t or 28ef s be notified Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of Wi | hat Country | ? |
| | 9211 STUART L | | | | 0735 | | U.S | 777 | |
| if, or items 23 caminer must by Funeral | 11. Merital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: | | es Decedent of H es, specify Cub | | Specify Yes or No- rto Rican, etc.) | | - American c, White, etc. | |
| | 15. Decedent's Educ | cation | 16a. Decede | nt's Usuet Occup | pation | 10 | 6b. Kind of Bus | sinass/Indus | try |
| ygiens, natural, tra Medical | (Specify only highest grade Elementery/Secondary (0-12) | College (1-4or 5+) | (Give ki | NOT use retire | | orking | | | |
| Con the | 8th | | | DOMES | | ma (First M. A. | N/ | | |
| B stor | 17. Father's Name (First, Middle, Last) MIGUEL | р | IVERA | | | ome (First, Middle, Mi EDES | aiden Sumeme |) MIRA | NIDA |
| marks marks matic | 19e. tnforment's Neme/Reletionship (Ty) | | | Address (Street | | LUES Bural Route Number, | City or Town. S | | |
| 27 is 27 is 4 tran | LLOYD S. MERRIT | | | | | 5, COLON | | | |
| I Item | 20a. Method of Disposition | 20b. P | Plece of Disposit | | | | Oc. Location - C | | |
| ury o | 1 ☐ Suriel 2 ☐ Cremetion 3 ☐ Ri 4 ☐ Donetion 5 ☐ Other (Specify) | emovel from Stete | | | | Y 28-00 | CLINTO | N, M | D |
| my inj | 21. Signeture of Funeral Service Ricense | 1 | 22.1 TA | ame and Addre | ss of Facility FUNE | RAL HOM | Е | | |
| 588 | 010 | aglar | 172 | 2 NORT | H CAPI | TOL ST., | NW WA | SH.D | C 20001 |
| ysician ledical aminer | 23a. Part1. Enter the diseese, or complete shock, or heert teilure. List this on Immediate Ceuse (Finel diseese or condition resulting in deeth) | Appira | tron | Prei | emiere | ia | | H | erval Between nset and Deeth |
| n and ial-transit Examiner | Second to the Person of the | Bus to 6 | or es a conseque | , , , , , , , , , , , , , , , , , , , | | | | | 75010 |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | T > > > | N/ | | | | | | Sh. |
| Medical | Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or | r as a conseque | nce of): | | | | | - Y |
| attending p for use as clan/Med | d | | | | | | | 1 | |
| by Physician/Me | Pert II. Other significant conditions con | tributing to death but not resu | ulting in the und | erlying ceuse giv | ven in Part I. | 23b. Did tob | _/ | | e cause of death? |
| be d | | | | | | | T | | |
| should should | | | | | | 24a. Wes an perform | | availa | autopsy findings ble prior to letion of cause th? |
| page 2 | | | | | | 1 ☐ Yes | 2 D/No | 1 🗆 Y | es 2 No |
| Be | 25. Wes case referred to medical exeminer? | oenitel: . | | 10 | | eth (Check only one |) | | |
| 岩 草 户 | 1 ☐ Yes 2 No | | ER/Outpatient 28b. Time of | 3LI DOA | | Home 5 Residen | | | |
| funeral funeral | 1 Netural 5 Pending 2 Accident investigation | 28e. Dete of Injury (Month, Dey Year) | Injury | M 1□ | rk? Yes 2 □ No | ZOG. Describe NOV | varjury occurre | | |
| al Director: After to in by the funeral Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he building, etc. (Specify | ome, ferm, stree | | | 28f. Location (Stre City or Town, | | or Aural A | oute Number, |
| Funer tely fill | 29e. Certifier (Check only one) 1 Certifying Physical Certifier (Check only one) 1 Certifier (Check only one) 1 Certifier (Check one) 1 Certif | Ictan: To the best of my knower: On the basis of examiner and menner steted. | wledge, deeth o tion end/or inves | ocurred at the tirestigation, in my o | me, date and place opinion, deeth occ | ee, end due to the cau | use(s) end men te and plece, ar | nner as state nd due to the | od. e cause(s) |
| To the comple | 29b. Signature and title of certitier | A 443 | | 29c. Licens | se number | 29 | d. Dete signed | (Month, Day | y, Year) |
| | Armo | MD ATT | India | 1-1)- | 2453 | 35: | 24 | Jan. | 2000 |
| | | - IVU | 1 | 1 | | | | 1 100 | |
| 3) | 30. Name and address of parson who cor | | | | VE., C | -101 CLI | NTON. | MD | 20735 |

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month 25. 2000 Jane P. Mountain January 12:40 P.M 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 8. Data of Birth (Month, Day, Year) Feb. 22, 1 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. Birthpleca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 1□M 2∰F Months Days Hours Min. Yrs. 78 Maryland 214 14 7723 1921 Usual Rasidance of Dacedant 10b. Counts 10c. City. Town or Location 10d. Insida City Limits 1XXVas 2□ No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3903 Winchester Lane 20715 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yes 20 No Specify: Specify 3√Widowad 4 □ Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) Office Manager Volunteer 18 Mothar's Nama (First Middle Maiden Sumama) 17. Fathar's Nama (First, Middla, Last)

20b. Place of Disposition (Nama of cematary, cramatory or other place) Jan. 29, 2000

22. Nama and Addrass of Facility Robert E. Evans

29c. Licansa number

Meadowridge Memorial Park

Rose Adams 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

7716 Aragorn Court Hanover Maryland 21076

16000 Annapolis Rd. Bowie Maryland 20715

Funeral Home, Inc.

20c. Location - City or Town, Stata

Elkridge Maryland

Approximete Interval Between Onsat and Daath

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

mp 20785

Physician

/Medicai **Examiner**

Examiner

Physician/Medical

P

Completed

Be

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Certification:

edicai

29b. Signatura and titla of certifiar

Physician

/Medical

Examiner

10a State

Directo

Funeral

by

Completed

Be

James Patterson

Marlene Harmon

19a. Informant's Name/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21 Signature of Funeral Service License

20a. Method of Disposition

1 Burlal 2 Cramation 3 Removal from State

Daughter

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examinations maint be a

Baltimore, Maryland 21215-0020

physician and the bunal-transit The law requires that the death certificate be axecuted use as I been signed by the should be detected to the page 2 has certificata funeral director, this After

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: ofter deeth. Director: Af

To the Hospital or Atterview ithin 24 hours effer der To the Funeral Directo completaly filled in by the

Registrar

bacteremia Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Disaase or injury that initiated avants rasulting in daath) Last Due to (or as a consaquance of): Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Respiratory faciling 24b. Wara sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Septor Shock 2PINO 1 ☐ Yas 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 DNatural 5 Panding 1 Yas invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) 4 \ Homicide 1 Dertifying Physician: To the best of my knowledge, daath occurred at tha tima, data and plece, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and plece, and due to the cause(s) end menner stated. 29e. Certifier

Drive

Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Day, 32. Ragistrar's Signatura

HUSD

eddress of person who complated cause of deeth (Item 23a) (Type, Pnnt)

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BEGS " a HAL

Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year John Joseph McCarthy, Jr. 8:22PM January 24,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. 8. Dete of Birth Min. July 22, 1933 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Washington DC 100 M 2□ F 579-44-9804 66 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 1 Yes 2XNo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7520 Surratts Road 20735 U.S.A. 14. Race - American Indian Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No. If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2000 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Disabled N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph McCarthy, Sr. Mary Margaret O'Dea 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Francis McCarthy (Brother) 11002 Waco Drive Upper Marlboro, MD 20772 20b. Plece of Disposition (Name of cemetery, crematory or other place) Jan. 29, 2000 20e. Method of Disposition 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State Washington DC Mt Olivet Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signeture of Funeral 9 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Be Completed

2

Funeral

Director

tem 27 la marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Introcram: If them 27 is marked other than "natural", or the any injury or other traumatic evant me.

Baltimore, Maryland 21215-0020

with the Meryland

death

or Attending Physician: The law requires that the death certificate be exacu attending for use signed by the i certificate director, this funeral After

Division of Vital Records. P.O. Box 68760.

Examiner Physician/Medical Be Completed by Certification: To death. 24 hours after deat Funeral Director: filled in by

| ert II. Other algnificant conditions of | ontributing to death but not res | sulting in the underlyin | g cause given in Part I. | 23b. Did tobacco use co | ontributa to the cause of death? 3 Probably 4 (A) (Inknown |
|---|--|------------------------------|---------------------------------|--|---|
| de . | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? N/A |
| Was case referred to medical examiner? | | | | eath (Check only one) | |
| 1 ☐ Yes 2 Dolo | Hospitel: 1 ☐ Inpatient 2 | ER/Outpatient 3□ | DOA Other: 4 Nursing | Home 5 ☐ Residence 6 ☐ Ott | her (Specify) |
| 7. Menner of Death 1. Netural 5 Pending 2 Accident Investigation | | 28b. Time of Injury | 28c. Injury et Work? 1 Yes 2 No | 28d. Describe how injury occur | rred |
| 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | nome, ferm, atreet, fectify) | lory, office | 28f. Location (Street and Num. City or Town, State) | ber or Rural Route Number, |

State Registrar

completely

within 2 ş

Medical

29b. Signeture and title of

30. Name and address of

31. Date filed (Month, Day, Year) JAN 2 7 2000

14

d cause of death (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

Hospital

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** URRUARY 4c. County of Deeth Muldoon 6157AM Kenneth /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Prince George's Lanham Doctor; s Community Hospital If Under 24 Hrs. If Under 1 Year 8. Dele of Birth (Month, Day, Year) May 23,1914 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Funeral Days Hours Months New York Director 065-03-1360 85 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Director Maryland Prince George's Mitchellville or 28a-1 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 20721-2734 U.S.A. 10450 Lottsford Road #309 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Yes 2 No 1 Never Merried 2 Merried White 8 1 ☐ Yes 2 ☒ No Specify: Specify py 3 5 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) American Gas Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Association Sales Manager 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 8 and Mental Muldoon Lucinda Maxwell Christopher Pearson 19e. Informent's Neme/Reletionship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) organization of Health and important: If Itam 27 is m any injury or other 10450 Lottsford Rd. #247 Mitchellville MD 20721-RoAnne Dahlen-Hartfield 20c. Location - City or Town, Stete 2734 20b. Plece of Disposition (Name of 20e. Method of Disposition Dele 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) January 22,2000 Clinton, Maryland Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 6633 Old Alexandria Ferry Raod Clinton, MD 20735 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** freumonia /Medical Immediate Cause (Finel 2 weeks diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. DU 2002. 2 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Records, à Crevu Atral FILMI 210 24a. Wes an eutopsy performed? 24b. Were autopsy findings svallable prior to Completed svallable prior to completion of cause of death? Diebeter mellidur N/A Les Molices. 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital ai or Attending Physician: Ti s after death. ii Director: After this certificat ed in by the funeral director, pa 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Dete of Injury (Month, Day Year) 27. Macoar of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier

State Registrar

29b. Signeture end title of certifier

reuld

30. Name and address of person who completed cause of beeth (Item 23a) (Type, Print) stimonalda Mo 32 Registrer's Signeture

DHMH 16 Rsv 6/95

29c. License number

025073

29d. Date signed (Month, Dev. Year)

00

Lonkon

JAN 2 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | State of M | larylan | | | | lealth a Death | and Me | | giene Reg. No. | 00 | 01: | 133 |
|--|---|--|-------------------|----------------------------|-----------------|---------------|-------------------------|------------|--------------------------------|----------------------|--------------|--------------|--|
| | 1. Decedent's Name (First, Middle, La | st) | | | | | | | 2. Date of De | eth | Vees | 3. Ti | ne of Death |
| Physician /Medical | Doris Anne Miles | | | | | | | J | Month January | Dey 14 | Year 2000 | 4: | 45 a.m. |
| Examiner | 4a Facility Name (If not Institution, give | e street and number |) | | | - 1 | 4b. City, To | wn, or Loc | ation of Deat | 4c. Co | unty of Dec | | |
| | Prince George's | | | | | | Cheve | - 4 | | | ice Ge | | |
| Funeral | 5. Sociel Security Number 6. 5 | Sex 7. A I□M 2∏ F | ge (In yrs. 63 | last birthday) Yrs. | Months | Deys | If Under : | Min. | 8. Date of Bir (Month, De | th y, Year) | 9. Bi | | tate or Foreign |
| Director | Usuel Residence of Decedent | | 0.5 | | | | | II. | March 1 | 1, 1930 | was | sning | ton, DC |
| ylend Mow | 10a, State 10b. County | | 10c. Cit | ty, Town or Lo | ocation | | | | | | | | de City Limits |
| e Mer | Maryland Prince | George's | Нуа | ttsvil | le. | | | | | | | 11 | Yes 2□No |
| 72 hours after death with the Merylend natural, or items 23a or 28a-f show are learning to part to provide a sted by Funeral Director | 10e. Street and Number | | | | 10f. Zip | | | | | 10g. Citizen | | ountry? | |
| ath w | 5032 38th Avenue | 45 111 5 1 | . = | 10 | 207 | | P1- O-1 | -1-0 (0 | 16 . M N. | U.S.A | Reca - Am | orlana Indu | 0.0 |
| r ttems 23a | 11. Marital Status 1 Never Married 2 Married | 12. Wes Deceden Armed Forces 1 Yes 2 X | ? | 13. | If Yes, spe | cify Cube | en, Mexican | , Puerto R | cify Yes or No lican, etc.) | | Bleck, Wh | | par1, |
| urs af | 3 ₩ Widowed 4 Divorced | If Yes, Give Year or Dates: | | | 1 Yes | 2 ∑ No | Specify: | | | Sp | ecity: W | hite | |
| ed within 72 hours ygiene. • The "neturel", rt, the Wedcel Ex Completed by | 15. Decedent's E | ducation | | 16a. Dece | dent's Usu | el Occup | petion | of workin | | 16b. Kind | of Business | s/industry | |
| within 7 ena. than 'n | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or | 5+) | | | se retired | during most d) | OF WORKIT | g | | | | |
| Hygiene. Hygiene. Ant, tre Me | 12 | | | House | wife | | | | · | Own H | | | |
| be fill H out out | 17. Father's Name (First, Middle, Last |) | | | | | | | (First, Middle | | mame) | | |
| d 2 should be filed within 72 hc h end Mental Hygiena. Tie marked other than "natur traumatic event, the Medical To Be Completed | Bergon V. Sigmon 19e, Informent's Neme/Reletionship | Time Print) | | 10b Maili | na Address | | | | Benne Route Numb | | own State | Zin Codel | |
| alth en 27 le r | Stephen Miles - S | | | | | | | | Hyatts | | | | |
| PPEE | 20e. Method of Disposition | 5011 | 20b. F | Plece of Disponentery, cre | | | | | Date | | ion - City o | | ate |
| 0 = = 5 | 1 ♥ Bunal 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specific | | | Veter | | | | 01 | /28/00 | Chelt | enham | , Mar | vland |
| 4 5 5 6 | 21. Signature of Funerel Servica Licar | | | 2 | 2. Name ar | nd Addre | ss of Facilit | v | | | | • | |
| Page 18 and | 100 au 0 st | 5-19 | 0000 | | | | | | e, P.A ue, Hy | | 11e. | MD 20 | 781 |
| centificate be associated as the bunda-transit as t | disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | e. 46 | | or es a conse | | | | C | r | | | | |
| net the deeth certificate be d by the attending physicial etached for use as the bur Physician/Medical | thet initiated events resulting in deeth) Lest | d | Due to (d | or as a consec | quence of): | | | | | | | | |
| 0 0 0 00 | Part II. Other significant conditions of | ontributing to death | but not res | sulting in the u | inderlying (| cause giv | ven in Pert i | | | tobacco us Yes 2□ | | ta to the co | 4 Unknown |
| been s should | | | | | | | | | | an autopsy ormed? | 246 | aveilable | opsy findings prior to on of cause |
| 0 - 5 - | | | | | | | | | 10 | Yes 2 | No | 1 🗆 Yes | No No |
| certificate harector, page | 25. Wes case referred to medical | | | 1 | | | 26. Plece | of Deeth | (Check only | one) | | | |
| S D | examiner? | Hospital: 1 Inpat | tient 2 | ER/Outpatie | nt 3 D | OA Oth | her: 4□ Nu | ırsing Hon | ne 5□Res | dence 6 | Other (Sp | ecify) | |
| After fune fune | 27. Manner of Deeth 1 Maturel 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not by | 0 | | 28b. Time o | М | | ry et rk? IYes 2□ | No | 8d. Describe | | | 7 | Month |
| | 4 HomicIde determined | 200. PIECE OF II | etc. (Specil | | | | mo doto oss | | | wn, State) | | | , individual, |
| Ne Hospital n 24 hours ne Funeral pletely filled edical C | | niner: On the basis | of examine | | | | | | | | | | ruse(s) |
| To the comple | 29b. Signeture and title of certifier | rhoe | lle | R | ²⁹ J | c. Licens | se number | 23 | - | 29d. Date s | igned (Moi | Day, Y | ear) |
| | 30. Name and address of person who | completed cause of ANHOU | death (iter | 300 (Type | Print) HO | SPIT | LAL A | Dr. | CHE | ERI | In | 20 8 | 21785 |
| State | 31. Dete filed (Month, Day, Year) | 32. Regis | trer's Signa | ature | 1 | | 7 | | | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene o

| 1. Decedent's Name (First, Middle, La | ist) | | ertificate of | Dodin | 2. Date of Deat | ng. No. | 3. Time of D |
|---|--|--------------------------------|---|--|---|---|---|
| DIANA M. MARBU | RY | | | | Month January | Dey 23 | Year 2000 6:12 |
| 4a Facility Name (If not institution, give | re street and number) | | T | 4b. City, Town, or I | 1 | 4c. County | |
| VALTES FORT HOWAR | RD DIVISION | | | FORT FOW | ARD | EAL | TIMPE |
| 214-48-3412 | ITM STE | In yrs. last birthda Yrs. | Months Days | | 8. Dete of Birth (Month, Dey, | Year) | 9. Birthplace (State or Country) ASHINGTON |
| Usuat Residence of Decedent 10a. State 10b. County Md . Anne A | | Oc. City, Town or I | | | | | 10d. inside City |
| 10e. Street and Number | | | 10f. Zip Code | | 11 | On Citizen of V | What Country? |
| 703 Westley | Road | | 2106 | 51 | | U.S | |
| 11. Marital Status Sep. | 12. Was Decedent Ev Armed Forces? | er in U,S. 13 | . Was Decedent of | Hispanic Origin? (S pan, Mexican, Puert | pecify Yes or No- | 14. Rac | e - American Indian, |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Of Year or Dates: | 5-170 | 1 ☐ Yes 2 ☒ No | | o rican, etc.) | Specify | ck, White, etc. |
| 15. Decedent's Ed (Specify only highest gra | ducation ade completed) | 16a. Dec | edent's Usual Occu | pation during most of wor | kina | 16b. Kind of Bu | usiness/Industry |
| Elementary/Secondary (0-12) | College (1-4or 5+) | life. | Unemploye | during most of wor | | | |
| 17. Father'a Name (First, Middle, Last | 1 yr. | | onembroke | | ne (First, Middle, M | | one |
| John Graham | | | | | die McVea | | , ay |
| 19e. Informant'a Neme/Relationship (| Type, Print) | 19b. Ma | ling Address (Stree | t and Number or Ru | ral Route Number. | City or Town. | Stete, Zip Code) |
| Addie McVea/Mothe | er | | | | | | o, N.C. 27401 |
| 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specif | | | emetory or other ple | atory, Inc. | -28-2000 | | City or Town, State Beltsville, |
| 21. Signature of Funeral Service Licer | | | 22. Name end Addr | ess of Fecility | | | |
| 23a. Part1. Enter the disease, or com | n. Sra | | | nington & coughs Ave | | | C. 20019 |
| Immediate Cause (Final disease or condition resulting in death) | e. METASTASI DA MALIGNANT | a to (or as a cons | equence of): | | | | |
| Sequentially list conditions | b | e to (or es a cons | | | | | 1 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | ING CHOLE | CYSTITIS | | | |
| that initiated events resulting in death) Last | d. | e to (or es e conse | equence of): | | | | |
| Part II. Other significant conditions of | contribution to death but | not regulting to the | underbring cause a | iven in Post I | 22h Did to | bacco usa co | ntribute to the cause of |
| HYPERIENSION, TO | | | | VOIT WIT OUT. | | as 2□No | 3 Probably 4 U |
| | | | | | 24a. Was ar perform | autopsy ned? | 24b. Were autopsy fin evailable prior to completion of car of death? |
| | | | | | 1□ Ye | s 2 No | 1 Yas 2 N |
| 25. Was case referred to medical | | T-11-1- | | 26. Place of Dea | ith (Check only on | a) | |
| examiner? 1 Yas 2 No | Hospital: | 2 ER/Outpatio | ent 3 DOA Ot | hor | ome 5 Reside | | er (Specify) |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Data of Injury (Month, Day Y | ear) 28b. Time Injury | Wo | iry at ork?] Yes 2 No | 28d. Describe ho | w injury occur | red |
| 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmined | 28e. Place of Injury building, etc. (| - At home, farm, a Specify) | treet, fectory, office | | 28f. Location (St. City or Town | reet and Numb , Stata) | er ot Rural Route Numb |
| 29a. Certifier 1 Certifying Ph | ysician: To the best of n niner: On the basis of ex and manner state | aminetion end/or i | th occurred et the transcription, in my | ima, data and place opinion, death occu | , and due to the ca rred at tha tima, da | use(s) and ma ite and plece, | anner as stated. and due to the cause(s) |
| 29b. Signature and title of certifier | - / | | 29c. Licen | se number | 29 | d. Dele signe | d (Month, Day, Year) |
| 30. Name and addrass of person who | ynelde | h (Ham 23a) (Turn | DS 7 | 454 | - | san | 23,200 |
| ARASTOO YAZDANI | M.D. 9600 | NORTH PO | | , FORT HO | MARD. MD | 21052 | |
| | | Tracket L | The state of the same | IIO | The same of the same of | 10 to | |

DHMH 16 Rev 6/95

DIRAM M. MARBURY

Color To MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

If Under 1 Year

10f. Zip Code

Library Technician

20b. Place of Disposition (Name of cemetery, crematory or other place)

CONTACT GUNSHOT WOUND OF HEAD

Due to (or as a consequence of):

Due to (or es e consequence of)

Due to (or as a consequence of)

Harmony Memorial Park

22. Name and Address of Facility

20743

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Days

Hours

13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)

Months

State of Maryland / Department of Health and Mental Hygiene Darion Miguel McCray 04135 AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Month 25, 2000 4c. County of Death Darion M. McCray 4b. City, Town, or Location of Death

Yrs.

10c. City, Town or Location

Washington

7. Age (In yrs. last birthday)

22

| Physician |
|-----------|
| /Medical |
| Examiner |

Funeral Director

the Maryland 28a-f show ns 23a or 28a-f shor Herne 6 "natural"

death 72 hours after Pages 1 and 2 should be in an in the lith and Mental in them 27 is marked or ith and Menter 17 is marked traumatic e permit. Pages 1 and 2 is Department of Heelth as Important: If fem 27 is any injury or other trau once.

21215-0020

Baltimore, Maryland

burial-tran be execut as tha the death certificata Box (080 Por P.O. á thet Records, 8 page The of Vital

/Medical Examiner or Attanding Physician: Division after deeth. filled in by 24 hours Hospital completely within 2 To the To the

4s Facility Name (If not institution, give street and number) Prince George's Hospital Center 5. Social Security Number 15 M 2□ F 216-17-2374 Usual Residence of Decedent 10a. State 10b. County DC Directo 10e. Street and Number 1227 Benning Road #3 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married py 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be George E. McCray, Jr. 19a. Informent's Neme/Relationship (Type, Print) George E. McCray, Jr. 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 9

25. Was case referred to medical 1 Nes 2 No edical Certification: To 27. Manner of Death 1 Neturat 5 Pending 2 ☐ Accident

Completed Be

Hospitat: 1 Xinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 1-25-2000 28b. Time of 5:32 investigation

6 Could not be 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number O.C.M.E.

28c. Injury et Work?

1 Yes 2 No

A

29d. Date signed (Month, Dey, Year) January 26, 2000

281. Location (Street and Number or Bural Reute Number D. City or Town, State) 1229 BLNNING, RD.

23b. Did tobacco uss contribute to the cause of death?

24a. Was an autopsy

performed'i

Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Deeth (Check only one)

2 🗆 No

SUBJECT SHOT SELF

CAPITOL HEIGHTS, MD

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings svallable prior to completion of cause of death?

17 Yes 2 No

11:57 P.M.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1⊠ Yes 2□ No

20743

Approximate Interval Between Onset and Death

Prince George's

14. Race - American Indisn, Black, White, etc.

Library of Congress

20c. Location - City or Town, State

2/ / /2000 Landover, Maryland

Black.

1977 Wash.,

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry Federal Government

USA

11,

18. Mother's Neme (First, Middle, Meiden Sumame)

Patricia Robinson

Date

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4317 Southern Ave., CapitolHeights, Maryland

Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC

of death (Item 23a) (Type, Print) 30. Name and address of person who co 111 Penn Street, Baltimore, Maryland 21201 HEODORE MIKE

31. Date file

4 Homicide

29a, Certifier

Megistrer's Signature

ROADWAY

7000

DHMH 16 Ray 6/95

State Registrar

JAH 2 1 2008 Server

DHMH-18 Rev 1/89

| 4 | No. |
|---|-------------|
| | hours |
| | within 24 |
| | executed |
| | 20 |
| | certificate |
| | death |
| | the |
| | that |
| | requires |
| | A.P. |
| | The |
| | PHYSICIAN |
| | TENDING |

FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last) 2 DATE OF OFATH 3. TIME OF DEATH PM 11: 40 M MONTH, YEAR MOORE JOSE 2000 2 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 86 80-01-0020 3-5-U.S. UIRG. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN MARINER HEALTH OF SOUTH MO P.G DIRECTOR CLINTON 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PRINCE GEORGES CLINTON 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? PISCATAWNY LANDING

12. WAS OCCEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KNO

IF YES, GIVE WAR OR DATES U.S.A. 2906 DR 20135 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify BY 3 Widowed 4 Divorced BLACK COMPLETED 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY S+h College (1-4 or 5+) 4,0 AUAILABIE SELF-EMPLUYED once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLES 70 ELISABETH MOORE notified 19a. INFORMANT'S NAME (Type/Print) LINTUN MD 20735 0 JAMES LAND INC MOORE Dr. must be 20a. METNOD OF DISPOSITION
1 Durial 2 Cremation 3 D
4 Donation 5 Other (Specify) PATE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata CREM TONG 121000 BELTSUILLE MD SAPEAKE 21. SIGNATURE OF SUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
STERLING FUNERAL SERVICE 23. PART I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. AUE N.E by the f medicai Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Pinal the disesse or condition VENTRICULAR FIBRILLATION OUE TO (OR AS A CONSEQUENCE OF): 5 minures resulting in dasth) event. MURTHAN ARTERX CORONARY DUE TO (OR AS A CONSEQUENCE OF DISEASE traumatic IYOAK CERTIFICATION Sequentially list conditiona, If sny, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior t other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 10 injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? IABETES any MELLI TUS 1 - YES 2 X NO Shows VASCULAR DISLASE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. 23 26. PLACE OF OEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? certificate h the State HOSPITAL : OTHER:
4 X Nursing Nome 5 - Residence 8 - Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF INJURY 28d. OESCRIBE NOW INJURY OCCURED marked, this (1 Netural 2 Accident 5 Pending BY After death 28e. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Tours State) 40 6 Could not be COMPLETED DIRECTOR , 4 Nomicide 200 item 29a. CERTIFIER

(Chack note of the course of THE FUNERAL DE filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 표분 Ceyen 22-2000 D 50653 1 -2 2 3 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GYAN CHAND SURANA-2 Deale 5851

Deale

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~2000

JAN 2 8

ruschtun 32, REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DAMI MUSTAPHA Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Year **Physician** 22, MUSTAPHA JAN. 2000 2040 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-10-86 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 KF 218-19-2083 13 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s or 28a-f sh be notified 15 Yes 2□ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3306 Niles St. 238 20906 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status Black White atc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) None None 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hi tent: If them 27 is manked off Mustapha Mansur Jinady 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 Mansur Mustapha -Father 3306 Niles St, Silver Spring, Md. 20906 20b. Place of Disposition (Neme of cematery, cremetory or othar pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 8 Buriel 2 Cramation 3 Ramoval from Stata George Wash Cemetery 1-26-2000 Adelphi, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary Inc. 21. Signeture of Funerel Service Licensee 411 Kennedy St, N.W., Washington, D.C. an 23a. Part1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart teilure. List only one cause on each line. **Physician** Asthma /Medical Immediate Ceusa (Final disease or condition resulting in death) **Examiner** Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Lest Due to (or es a consequence of): Box 68760, the Due to (or as a consequence of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. detached 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were eutopsy findings 24e. Wes an autopsy performed? svailable prior to completion of causa of death? Dage 2 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Division 1 Naturel 5 Pending after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicide Hospital 24 hours 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dale and place, and due to the cause(s) and manner as stated.

We dicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 To the 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) O.C.M.E JAN. 23, 2000 2 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 2000

DHMH 16 Rev 6/95

ORIGINAL

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

| | 1. | Decedent's Ner | ne (First, Midd | dle, Last) | | | | | | | | 2. Date of De | | | 3. Tir | ne of Deeth |
|--|--|--|--|--|--|--|--|--|-----------|--|--|---|---|--|--|--|
| ician | | Micheal | l Joset | oh Ma | nue1 | | | | | | | Month Januar | Day y 8, 20 | Year | 7 : | 50 PM |
| dical niner | 40 | Fecility Name | | | | mber) | | | T | 4b. City, Town, | | | | ty of Death | | |
| | I | Prince (| Georges | s Hos | pital | Cente | r | | | Cheverly | 7 | | Prin | ice G | enroe | 25 |
| | 5. 3 | Social Security | Number | 6. Sex | | | rs. last birthday) | If Under Months | 1 Year | If Under 24 F | irs. | 8. Dete of Birt (Month, De | th v. Year) | 9. Birth | hplace (S | tate or Foreign |
| | | 439-25-7 | | 11.4 | M 2□ F | | 28 Yrs. | | 20047 | | | July 20 | 5, 1971 | Lou | isia | na |
| | - | suat Residence de. State | of Decedent 10b. Count | by | | 10c. | City, Town or Lo | ocation | | | | | | | 10d Insi | de City Limits |
| ŏ | | Md | | | orges | | | | | | | | | | | Yes 2 No |
| 6 | 10 | e. Street and Nu | | e Ge | orges | 16 | mple Hi | 10f. Zip | Code | | | | 10g. Citizen o | Whet Co | untry? | <u> </u> |
| by Funeral Director | | | | | | | | | 748 | | | | | | | |
| - | 11. | 3001 B1 | tanen A | | 2. Was Dec | edent Ever In | U,S. 13. | | | Hispanic Origin? an, Mexican, Pu | (Spec | ify Yes or No | United 14. R | ace - Amer | rican India | an, |
| | | 1 Never Man | | | Armed For 1 Yes If Yes, Gir Year or D | 2 XNo | | 1 Yes, spec | | | ierto H | ican, etc.) | | eck, White | | |
| | - | /0- | 15. Decede | ent's Educa | ation | | 18e. Dece | dent's Usua | at Occup | petion during most of | s an ede îm | | 16b. Kind of | Business/I | Industry | |
| | - | Elementery/Sec | ondery (0-12) | 7 | College (| - | life. | DO NOT us | se retire | during most or t | WOIKIN | | | | | |
| | | 12 | | | | | Lon | g Dis | tano | e Telep | | | Teleco | | icati | ons |
| | 17. | . Father's Name | | , Last) | | | | | | | | | Meiden Sum | eme) | | |
| | L | John Ma | | | | | | | | Delori | | | | | | |
| | 19 | a. Informant's N | | | | | | | | t end Number or | | | | | | 07/0 |
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| | - | 1 Burial 2 | Cremation | | moval from | State | cemetery, cre | emetory or o | ther ple | | | | | | | |
| | 21 | 4 ☐ Donation 1. Signature of F | | | | | | | | RIAL PAI | | | | | A | |
| | 1 | 14/ | 1 | 1 | , | | | | | NDER S. | | | | | | |
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* 11.7 = 10.5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** N Willie Mae Newton Month 20° 2000 2:10 AM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Glady Spellman Nursing Home Cheverly Prince Georgies 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
7. 1 Vrs. Months Deys Hours Min. 5-20-25 239-56-6119 Birthplece (State or Foreign Country) **Funeral** 1□M XX F North Carolina Director Usuel Residence of Decedent with the Marylend Prince Georgies Oc. City, Town or Location Forestville 10d. Inside City Limits d 2 should be filled within 72 hours effer death with the Marylen in end Mentel Hygiene.
7 is merked other than "neturel", or fterms 23s or 28s-4 show traumetic svent, the Med call Emerical countries. XX Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2900 Mercy Way 20785 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Stetus Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: Black þ •3X Widowed 4 □ Divorced Completed 16a. Dacedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 10th Meat Inspector Pvt. Company 18. Mother's Neme (First, Middla, Maidan Sumeme) 17. Fether's Neme (First, Middle, Last) Willie Corbett Mary Lou Crumpler 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 sh Depertment of Health end Important: If Item 27 is m eny injury or other traum pace. 19e. Informent's Name/Reletionship (Type, Print) Mary J. Williams /Daughter 1311 Alberta Dr., Forestville, MD. 20743 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition ♦ Durlet 2 ☐ Crametion 3 ☐ Removal from Stete Pilgrim Rest Bapt. CH. 4 □ Donetion 5 □ Othar (Specify) 1-26-00 Harrells, NC. 22 Name and Address of Facility Cuffee Funeral Services 6815 Wilburn Dr. Cap. Heights,MD. 20743 tions that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, cause on each lina. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Examiner Sepsis The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate causa. Enter Undarlying Ceuse (Disease or injury that initieted avents resulting in deeth) Lest physician er s the burief-t failure Respiraton on muchanical Box 68760 Physician/Medical ventilation Renal hemodialysis Failure on 23b. Did tobacco use contribute to the cause of death? ed by the s Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Left Nephrectorny Status Records, þ 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy Completed peed Cerebrovascular accident certificate hes l 1610 Hypertension 1 Tyes 2 Divo 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case raferred to medical or Attending Physician: Be 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpetient 3 | DOA this 28e. Deta of Injury (Month, Dey Year) funerel 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturel 5 Pending death. 1 Yes 2 No investigation hours efter death unersi Director: A ly filled in by the f 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide n 24 hous. the Funeral Direction 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. To the To the F 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier Nancy Kalpara Gimothy D0052848 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print) NANCY K TIMOTHY 74 th 4410 AVENUE LANDOVER HILLS 31. Dete filed (Month, Day, Year)

JAN 2 4 2000 32. Ragistrer's Signetura State

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JANUARY 05, 2000 0640 JULIET C. NWANERI 4c. County of Death 4b, City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) GROW MEDICAL CENTER PRINCE GEORGES MALCOLM CAMP SPRINGS Hours Min. 8. Dete of Birth Month, Dev. Seas 1983 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1□M 2K F Months Devs Washington, D.C. 578-08-9501 16 Usuel Residence of Decedent 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20747 U.S.A. 6505 Elmhurst Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11 Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 11th Student Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Godfrey Nwaneri Dorothy Ekeji 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Godfrey Nwaneri/Father 6505 Elmhurst Street, District Heights, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 01/15 1 Burial 2 □ Cremetion 3 □ Removel from Stete Ft. Lincoln Cemetery 2000 4 Donetion 5 Other (Specify) Brentwood, Maryland 21. Signeture of Funerel Service Licensee J. B. JENKINS FUNERAL HOME Percen 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) PROBABLE ARRYTHMIA CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contributa to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 Yas CARPIAC TRANSPLANT DUE 24b. Were autopsy findings aveileble prior to HYPERTROPHIC CARDOMYOPATHY (20 MONTHS 24e. Wes an eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? 1 Yes 2 No iner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 1 Neturel 5 Pending Investigation

1 Yes

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner as steted

Examine physician and s the burial-transit deeth certificate be executed Box 68760. signed by the e 0 Division of Vital Records. s certificate hes b Attending Physician: director, this funeral * Hospital or Att.
* hours after deeth.
* I Director: After * by the fur After

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Hygiene. other than "natura ent, the Wed-cal E

7 is marked other traumetic event, i

Item 27

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Physician /Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Menyland ent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Physician/Medicai Completed Be 2 Certification:

To the Hosp within 24 hor To the Fune completely fi

State

Registrar

29b. Signature GOLLE JR

2 Accident 3 Sulcide

4 T Homicide

29a. Certifier

6 Could not be determined

ned cause of death (Item 23a) (Type, Print) HOSP (TAL MDI 3001

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) epd manner/stated 1 29d. Date signed (Month, Day, Year) 29c. License number

DRIVE, CHEVERLY

281. Location (Street and Number or Rural Route Number, City or Town, State)

0005 - 3 MAL

the state of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

04141

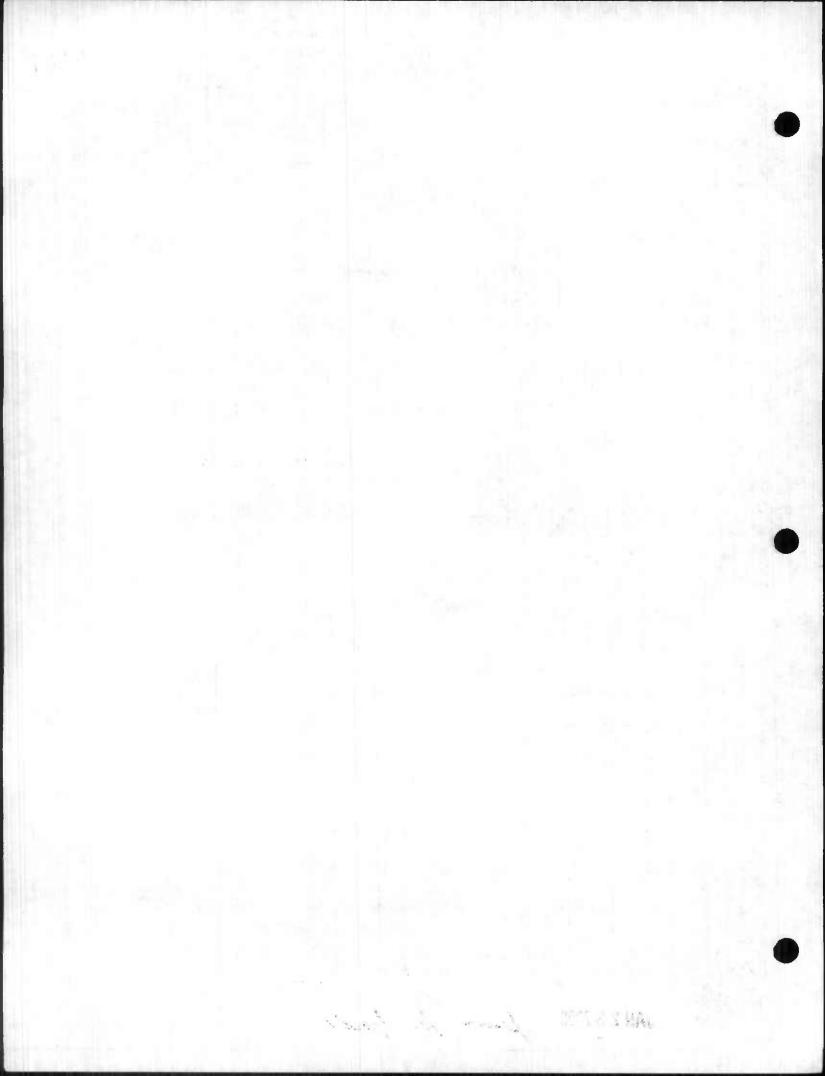
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|---|--|--|--|--|---|---|--|--------------------------------------|--|
| nysician Medical | 1. Decedent's Name (First, Middle, Elton James Nicl | | | | | 2. Date of De Month Januar | Day | Yaar | Time of Death :35 a.m. |
| xaminer | 4a Facility Name (If not Institution, 4011 Crittenden | | or) | | 4b. City, Town, or Hyattsvi | | | of Death e Georg | ge's |
| neral ector | 5. Social Security Number 028–16–7778 | 3. Sex 7. 1 ☑ M 2 ☐ F | Age (In yrs. lest birth | mdey) If Undar 1 Years. Months Day | | 8. Date of Bir (Month, De Sept. | y, Year) | 9. Birthplece Country) Massacl | (State or Foreign |
| 3 | Usual Residence of Decedent 10a. State 10b. County Maryland Prince | George's | 10c. City, Town | | | | | | nalde City Limits |
| ust be notified at ral Director | 10e. Street and Number | George 5 | Hyattsv | 10f. Zip Code | | | 10g. Citizen of V | | ⊠ Yes 2 No |
| al Dir | 4011 Crittenden | Street | | 20781 | | 3.4 | U.S.A. | mat oodiniy i | |
| by Funeral | 11. Marital Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced | If Yes Give | s? | 13. Was Decedent of If Yes, specify C | f Hispanlc Origin? (Suban, Mexican, Puert o Specify: | pecify Yes or No o Rican, etc.) | Specify | e - Amarican In kk, White, etc. | |
| pete | 15. Decedent's | Education grade completed) | 16a. I | Decedent's Usuel Occ Giva kind of work don life. DO NOT use ret | supation ne during most of wor | king | 16b. Kind of Bu | | |
| Completed | Elementery/Secondary (0-12) | College (1-4- | | etective/S | | | | George' e Depai | s County |
| To Be Co | 17. Father's Neme (First, Middle, La Francis Joseph N | | | | 18. Mother's Nar Theresa | | , Maiden Surnem | | CINCIIC |
| - | 19a. Informant's Name/Reletionship | | | Mailing Address (Stre | | | | | |
| | Gladys Nicholls 20a. Method of Disposition | - Wife | | 1 Critten | | Dete Dete | sville, | | |
| and and | 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | ecify) | (0 | Disposition (Name of cremetory or other pullincoln Cet 22. Name and Add | netery | 2/2/200 | | | Maryland |
| cian | 23a. Part 1. Entar tha disaasa, or co shock, or heart feilure. List or | omplications that country one course on each | Sad the death. Do no | Gasch's E 4739 Balt | uneral Ho imore Ave | nue, Hya | | App | 20781 proximate rival Between set and Death |
| lical iner | Immediate Cause (Final disaase or condition resulting in death) | a. Stoma | Due to (or as a co | | | | | 6 | Months |
| use as the bunal-transit | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c | Dua to (or as a co | | | | | | |
| | Part II. Other significant conditions | contributing to deat | but not resulting in | the underlying cause | given in Pert I. | 23b. Dld | tobacco use co | ntribute to the | cause of death? |
| detached for representation of Physicia | Coronary Artery | | | | | 1 🖾 | Yes 2 No | 3 Probabl | y 4 Unknown |
| | | | | | | Ode Wes | an autopsy | 24b. Were a | utopsy findings le prior to |
| 2 should be | | | | | | | ormed? | | ition of cause |
| Sompleted | | | | | | perf | Yes 2∯No | comple of deat | ition of cause |
| Be | 25. Was case referred to medical axaminar? | Hospital: | Nicet 2 F9/Out | positions 20 DOA | Whor: | perf | Yes 2 No | comple of deat | h? |
| director | axamhar? 1 Yes 2 X No 27. Menner of Death 1 X Naturel 5 Pending Investiga | 28e. Date of I (Month, | | ime of jury 28c. Ir | Other: 4 Nursing I | perf 1 □ ath (Check only doma 5 🖾 Ras | Yes 2∯No | comple of deat 1 Ye er (Specify) | h? |
| director | axaminar? 1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending | 28e. Date of I (Month, tion at be ad 28e. Place of | njury 28b. Ti Dey Year) In | ime of jury 28c. Ir | Other: 4 Nursing I | ath (Check only toma 5 🖾 Ras 28d. Describe | Yes 2√ No one) idence 6 □Oth | comple of deat 1 Ye er (Specify) | ition of cause h? ss 2□ No |
| Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending Investiga 2 Accident 6 Could no determine 29a. Certifier 1 Certifying | 28e. Date of I (Month, tion at be ad 28e. Place of | njury Dey Year) 28b. Ti In Injury - At home, fan etc. (Specify) st of my knowledge, of examination and | me of jury M 28c. Ir jury M 1 m, street, factory, office death occurred at the | Other: 4 Nursing Figury at Vork? Yes 2 No | ath (Check only) from 5 \$\infty\$ Ras 28d. Describe 28f. Location City or To | Yes 2 No one) idence 6 □Oth how injury occur (Street and Numb wm, Stete) cause(s) and ma | comple of deat 1 | uta Number, |

DHMH 16 Rev 6/95

State

Registrar

JAN 2 8 2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

| 1. De | ecedent's Name (F | First Middle | la Last) | | | | or arroa | ie or | Death | | 2. Date of De | Reg. No. | 0 (| 0 (| 3. Time | of Death |
|--|--|--|---|---|--|--|--|----------------------------------|--|--------------------------|--|---|--|--|---|--|
| ian cal | RAYMOND | I | LEE | | NEWBEGI | N | | | di Oit To | | Month JANUAR | Y 27 | , 201 | | | 30 PM |
| CI | facility Name (If no IVISTA ME ocial Security Numi | EDICAL | L CEI | NTER | 7. Age (In yrs | . last birthde | y) If Under | er 1 Year | LA P | LATA | 8. Date of Bi | (| CHAR: | LES | lace (Sta | e or Foreign |
| | 7-22-063 al Residence of De | | X X | M 2□ F | 73 | Yrs. | Months | Days | nours | MIRT. | Aug. 4 | , 192 | 26 | Main | e | |
| | ryland 10 | ob. County | Mar | v's | 10c. C | ity, Town or Charl | Location | Hall | | | | | | 1 | | City Limits |
| 10e. | Street and Number 7700 Arb | er | | | | | | p Code | 20622 | | | _ | zen of W | What Coun | try? | |
| 11 | Marital Status Never Married Widowed 4 | ,, | ried | Armed F | 2□No 19 | u,s. 1 45- | 3. Was Dece If Yes, spo | | lispanic Orig an, Mexican Specify: | gin? (Spec , Puerto P | cify Yes or No lican, etc.) | | | Americ k, White, | etc. | |
| | 15 | i. Decedent only highes | it's Educe | ation com <i>pleted)</i> | 13 | 16a. De (Gi | cedent's Usi ve kind of w DO NOT | ork done use retire | during most | of workin | g | | S. N | isiness/inc | | |
| 17. F | father's Name (First Raymone | | | n, Sr | | ile co | rurgi | 3 t | | | (First, Middle Laffat | , Maiden | | | | |
| 20a. I | tricia A Merilod of Disposi Murial 2 0 0 Donation 5 | ition Cremation ☐ Other | 3 □Rei | | 20b. | Placa of Dis | position (Na rematory or | ame of other plan | ce) | | Charlo Date 03-200 | 20c. Lo | ocation - | City or To | wn, State | |
| Sequif any cause that I result | MARK G. In 1. Enter the c shock, or heart fa sediate Cause (Finase or condition litting in death) uentially list condit y, leading to imme se. Enter Underly se (Disease or Injunitiated events titing in death) Last | BROHdisease, or allure. List | a. b. | ations that couse on Ca | O0053 caused the deceach line. Due to O Due to O | ath. Do not (or as a consor as a consor as a cons | 22. Name s HE HUI O. BOX enter the mo act requence of equence of | and Addrew NTT F | y (| DORF cardiac or | éase | C. LAND arrest, | 206 | 04 | Onset a | nate Between Ind Deeth Syn |
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| Sequification of the sequence | MARK G. Part 1. Enter the cashock, or heart fall sediate Cause (Final ase or condition liting in death) uentially list condition liting in death) uentially list condition liting in death) uentially list condition in death) list case referred examiner? uentially list condition in death) Was case referred examiner? uentially list condition in death) Was case referred examiner? uentially list condition in death list case and list case are list case are list case and list case are list case and list case are li | BROHdisease, or allure. List lions, idiate ng irry t t lion to medical | a. b. c. d. Hopgation | ations that cause on the cause of the cause | Due to (death but not re | (or as a consor as | 22. Name a HE HUI O BOX onler the more the more the more the more the more than the mo | cause gives 28c. Injury World 10 | Yen In Part I. | DORF cardiac or | 23b. Did 1 24e. Weiperl | tobecco ves 2 yes 2 yes 2 one) idence how injur | 206 uae corr No psy No 6 Otherry occurr | 04 ntribute to 3 Proi | o tha cau bebly ere autopallable pr mpletion death? Yes | se of death? Be of death? Unknow sy findings of to cause |
| Sequiresul Sequiresul Sequiresul Feat I 25. Ween 1 27. M 1 20 34 | MARK G. F. 11. Enter the c shock, or heart fa sediate Cause (Finase or condition liting in death) uentially list condition liting in death) uentially list condition in the sed of the sediment of the sed of | BROHdisease, or allure. List all tions, idiate and try to medical to medical to medical determines to Could a determine the control of the co | a. b. c. d. | ations that cause on the cause of the cause | Due to (death but not re | (or as a consor as | 22. Name a HE HUI O BOX onter the mo act lequence of equence of underlying underlying tient 3 0 0 M street, factor | cause gives 28c. Injury, office | yen in Part I. 26. Place ner: 4 Nu yet 'Yes 2 1 | DORF cardiac or Als | ARY respiretory (Check only or Tolly or | tobecco tobecco s en eutopomed? Yes 2 one) idence how injur (Street an own, State | 206 uae corr No sy of No of No of No and Numbers of Aumbers of Aumbers | 04 ntribute to 3 Prol 24b. Www.co.of 1 [] er (Specified | o tha cau bably ere autopallable pr mpletion death? Yes | nate Between Ind Death Supering the second death? But Unknown Syfindings of to of cause Unwber, |

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| State of Maryland / Department of Health and Menta | al Hygiene |
| Certificate of Death | Reg No |

If Under 1 Year

Days

| OS | SONT |
|----|-----------------------------------|
| | Physician /Medical Examiner |

Jere R. Ossont

11 M 2□ F

1. Decedent's Name (First, Middle, Last)

5. Sociel Security Number

086 36 4743

2. Dete of Death Month **JANUARY**

If Under 24 Hrs.

Hours

04143 3 Time of Death

4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) BOWIE BOWIE HEALTH CENTER 7. Age (In yrs. last birthday)

55

Yes

22,2000 4c. County of Death

1944

12:10P.M.

9. Birthplace (State or Foreign Country) New York

*Funeral Director

filed within 72 hours after death with the Maryland "natural", than other i other traumatic event. permit. Pages 1 and 2 abould be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event and any Injury or other traumatic event and any Injury or other traumatic event

Baitimore, Maryland 21215-0020

or items 23s or 28s-f show the Medical Exerciper must be notified at

Physician /Medical Examiner

The law requires that the death certificate be executed and attending physician for use as the buna use as the should be detached the 3 signed peen page 2 this certificate has or Attending Physician: after death. after death.

Director: After this certification by the funeral director, filled in by

P.O. Box 68760,

Division of Vitai Records,

Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Funeral Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Coda 7216 Old Chapel Drive 20715 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mental Stetus 1 ☐ Yes 2 ☑Xio If Yes, Give Year or Dates: 1 Never Merried 25 Merried 1 ☐ Yes 2010 Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Info. Specialist 17. Father's Name (First, Middle, Last) Willard E. Ossont 19a. Informant's Neme/Relationship (Type, Print) Carolyn C. Ossont Wife 20e. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removel from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility nplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediete Ceuse (Finel neoselatie Ard WASCULAR disease or condition rasulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to Immediate ceusa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Be Completed by 25. Was cesa referred to medicel 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Medicai Certification: To 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding Investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, date and place, and due to the cause(s) and mannar as statad.

**Continuous Continuous Continuo 29a. Certifier 29b. Signeture and title of certifier 29c. License number

10d. Inside City Limits to Yes 2 □ No 10g, Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify:

PRINCE GEORGES

White 16b. Kind of Business/Industry U.S. Government

23,

18 Mother's Nama (First, Middle, Maiden Sumame)

Lorraine Hoobler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7216 Old Chapel Drive Bowie Maryland 20715

20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 28, 02000 20c. Location - City or Town, State Alexandria Virginia

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715 Approximate Interval Between Onset end Death

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Ware autopsy findings available prior to completion of cause of death?

2 No

Yes 2 No

Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Date signed (Month, Day, Year)

O.C.M.E.

JANUARY 23,2000

ess of person who completed ceuse of death (Item 23a) (Type, Print)

M.D 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Mo

32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

To the Hospital of within 24 hours at To the Funeral D completely filled in

The state of the s

3AN 2 7 2686

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 10

| sician | 1. Decedent's Neme (First, A | fiddle, Last) | | | | tificate of | | 2. Data of D | | | ima of Death |
|---|--|--|---|--|--|--|---|--|---|---|--|
| | Hazel V. P | oliks | | | | | | Janua | ry 19 | Yaar 2000 8 | :15 A.M. |
| ledical aminer | 4a Facility Nama (If not instit | tution, giva st | reet and number) | | | | 4b. City, Town, or | | - | | |
| | Crofton Conv | alesce | nt Cente | r | | | Crofton | | Anne | e Arunde | 1 |
| eral | 5. Social Security Number | 6. Sex | | e (In yrs. le | ast birthday) | If Under 1 Yae Months Devi | | | lirth Dey, Year) | 9. Birthplece (S | Stete or Foreign |
| tor | 002 10 1440 | | M ŽŪĀF | 84 | Yrs. | | | | 15, 191 | | |
| | Usuel Residence of Deceder 10a. State 10b. Co. | | | 10c. City | , Town or Lo | cation | | | | 10d. Ins | side City Limits |
| rector | - W- H1.11 | | 1 1 | | | | | | | 10 | Yes & No |
| 9 | Maryland Ann | e Arun | del | Cro | ofton | 10f. Zip Code | | | 10g. Citizen of V | What Country? | 11.71 |
| ā | 1807 Reynold | e Cour | + | | | 2111 | /. | | | | |
| Funeral Director | 11. Meritel Stetus | | 2. Wes Decedent | Ever In U,S | S. 13. V | | Hispenic Origin? (S ban, Mexican, Puar | Specify Yas or N | | States e-Amarican Ind | lan, |
| by Fur | 1 ☐ Never Merried 2 ☐ 3XXWidowed 4 ☐ Divo | | Armed Forces? 1 Yes 2 1 If Yes, Giva X Yeer or Dates: | | | Yes, specify Cu | | to Rican, atc.) | Specify | ck, White, etc. White | |
| | 15. Dece | dent's Educa | ation | | 16e. Deced | ent's Usual Occi | pation | adela a | 16b. Kind of B | usiness/Industry | |
| Completed | (Specify only hi | | completed) College (1-4or 5 | 5+) | | | during most of wo | nking | | | J. 71 |
| Con | 12 | 0 | | | Soci | al Worke | _ | | | Governm | ent |
| BeC | 17. Fathar's Nama (First, Mid John Vignea | | | | | | | me (First, Midd ine Laf | ie, Meiden Sumen Ford | ne) | |
| 10 | | | | | I | | | | | | |
| To | 19e. Informent's Neme/Reiet | | | | | | et end Number or F | | | |) |
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| | 4 Donetion 5 Other | | | 1101 | | . Name end Add | | - 7 | Olowiis | VIIIC IIG | Tylund |
| once. | M. A. | 1 | 0,0 |) | | | Evans F | uneral : | Home, Ind | с. | |
| | "Human | \ \alpha | D:00 | 2 | 1 | 6000 Anr | apolis R | d. Bowi | e Maryla | nd 20715 | oximate |
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Meeterl & By

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Year Month Edward Powell. 21 2000 January 6:18PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washing 8. Date of Birth (Month, Day, Year) Sept. 24, 1940 North Carolina 3012 Kingsway Road 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex 1 → M 2 ☐ F Months 59 Yrs. 578-52-8659 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □XYes 2 □ No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3012 Kingsway Road 20744 United States 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. African 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced American 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Firefighter Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) John Powell, Jr. Christine Miller 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye A. Powell - Wife 3012 Kingsway Rd., Ft. Wash., M.D. 20744 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 1/25/2000 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery Brentwood, MD 22. Nama end Address of Fecility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 111 Muchou ther the disease, or complications that eaused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nolo Cancer disaase or condition resulting in death) Due to (or es e consequence of): Sepsis Due to (or es e consequenca of) Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 © Unknown 24e. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

or Attending Physician:

Pages 1 and 2 should be filment of Health and Martal Hamt. If Item 27 is marked off lury or other traumatic ever

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

8

Directo

Funeral

ğ

Completed

Be

the Manfand

filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner the burial-transit signed by the at d be detached for Completed by page 2 luneral director, Be Medical Certification: To To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the lun

certificate

this

After

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated avents resulting in deeth) Last

25. Was case referred to medical examiner?

1 Yes 2 No

27. Mennar of Deeth

1 Meturei

2 Accident

3 Suicide

29e. Certifiar

4 Homicide

(Check only one)

1□ Yes 2☑ No 26. Place of Death (Check only one)

24b. Wara autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 1 Yes 2 No 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated.

29b. Signatura and title of continu Municily

5 Pending investigation

6 Could not be determined

29c. License number D0052999 29d. Data signed (Month, Dey, Year) 01/24/2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) RAHIMIAN MD ALI

7801 old Branch AVE #409 Clinton MD

State Registrar

31. Dete filed (Month, Dey, Year) JAN 2 7 2000 32. Registrer's Signeture

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

0001 7 5 MAE

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O

| | Decedent's Name (First, Middle, Last | " | | Certifica | ile OI I | Jealii | 2. Date of Dea | | | Time of Death |
|--|--|---|--------------------------------|-----------------|------------------------------------|--|--|---------------------------|--|---|
| Physician | and the same of th | edersen | | | | | Month January | Day 7 24, 20 | Year 000 2: | :20 a.m. |
| /Medical Examiner | 4a Facility Name (If not Institution, give | street and number) | | | 4 | b. City, Town, or L | · | | | . 20 a.m. |
| CAUTIMIET | Collington Episcop | al Life Ca | are Comm | unity | M | itchellv | ille | Prince | e George | e's |
| Funeral Director | 5. Social Sacurity Number 6. Sa 046-38-4531 | 7. Aga | (In yrs. last birth | | ar 1 Yaar s Days | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day Jan. 1, | h (Year) | 9. Birthplace Country) | (Stata or Foreign |
| 2 . | Uaual Rasidance of Decedent 10a. Stata 10b. County | | 10c. City, Town | or Location | | | | | 104 % | nside City Limits |
| th the Maryland or 28a-f show a notified at | Maryland Prince G | eorge's | | ellvil | le | | | | | Yes 2 No |
| 2 -4 - | 10e. Street and Number 10450 Lottsford R | oad | | 10f. 2 | 2072 | 1 | | U.S.A. | | |
| OOZO hours after death v hours, or thems 23 al Examiner man d by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates: | | | edent of H pecify Cuba 2☑ No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecity Yes or No- Rican, atc.) | 14. Rac Bla Specifi | ce-American In ck, Whita, atc. ^{y:} White | |
| Maryland 21215-0020 d 2 should be filed within 72 hours at th and Merial Hygiene. 7 is marked other than "natural", or treumedic event, the Medical Exam To Be Completed by F | 15. Decedent's Edu (Specify only highest grad | cation le complated) Collega (1-4or 5- | | | vork dona d use retired | etion turing most of work) | king | | usiness/Industry | 1 |
| Co merced N | 17. Fathar's Nama (First, Middla, Last) | 4 | | House | wife | 18. Mother's Nem | a /First Middle | Own Ho | | |
| and dibe | T 1 11 11 1 | SS | | | | Priscil | | | , | |
| To To | 19a. Informant's Name/Relationship (7) | | 19b. | Mailing Addre | ss (Street | and Number or Rui | | | Stata, Zip Code | (e) |
| C TO PM In | William F. Peders | | | | | , N.E., | | | | |
| other other | 20a. Mathod of Disposition | | 20b. Place of l | Disposition (A | eme of | e) | Date | 20c. Location | - City or Town, S | State |
| Pages hant of my or o | 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | Ramoval from Stata | | olitan | | | 1/24/00 | Alexand | lria, Vi | rginia |
| Baltimore, permit. Pages 1 a Department of Hes Important: if Hem any injury or othe price. | 21. Signature of Funeral Sarvice Licens | - 1 g | 201 | | | ss of Facility ineral Ho more Ave | | | le. MD 1 | 20781 |
| | 23a. Part1. Entar tha disaasa, or compl ahock, or haart tailura. List only or | lications that caused | tha daath. Do no | - | | | | | App | roximete rval Between |
| physician and sub-transit sub- | Immediata Causa (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Diseasa or Injury | b | ocardia Oua to (or as e co | onsequence o | (): | n | | | | |
| ficate be physicians the burners of | resulting in deeth) Last | c | oua to (or as a co | nsequance of |): | | | | | |
| deeth cer deeth cer e attendin ed for use | Part II. Other algnificant conditions cor | ntributing to death but | not resulting In | tha underlying | cause giv | en in Part I. | 23b. Did t | obacco use co | ontribute to the | cause of death? |
| dS, P.O. BOX ires that the death cert signed by the attending d be detached for use of | Hypertension, Rec | | | | | | 101 | res 2∑ No | 3 Probably | 4 Unknow |
| Dor requirements should | and Urinary Tract | Infection | | | | | 24a. Was perlo | an autopsy med? | availabl | utopsy findings le prior to tion of cause 1? |
| The law page 2 | | | | | | | 101 | es 2 No | 1 □ Yas | s 2 No |
| r Vital Properties of contificate director, pag | 25. Was casa refarred to medical axaminer? | | | | | 26. Place of Dea | th (Check only o | ne) | 1 | |
| VISION Of VITA Attending Physician: A death. ector: After this certific by the funeral director. iffication: To Be (| 1 ☐ Yes 2 ☒ No 27. Menner of Death 1 ☒ Naturel 5 ☐ Panding 2 ☐ Accident invastigation | 1 ☐ Inpatier 28a. Data of Injun (Month, Day | 28b. Ti | | 28c. Injun World | 4 XX Nursing H | ome 5 Resident | | | |
| DIVISION OF To the Hospital or Attending Physics 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: | 3 Suicida 6 Could not be 4 Homicida datamined | 28a. Place of Inju- building, atc. | ry - At home, fan (Specify) | m, street, fact | ory, office | | 28f. Location (S City or Tow | | ber or Rural Ro | uta Number, |
| DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi | | elclan: To the best of ner: On the basis of a and mannar stat | examination and | | | | | | | |
| To the comp | 29b. Signatura and titla of certifier | 1 / | ma | 2 | 9c. License | | | 29d. Date signe | ed (Month, Day, | Year) |
| | I we will. | 4 / | 1.19 | | J 20 | 7079 | | January | y 24, 20 | 000 |
| (6) | 30. Nama and addrass of person who co | ompleted causa of de | ath (Item 23a) (T | ype, Print) | | | | | | |
| | Don H. Yablonowitz | , M.D. 74 | 404 Exec | utive | P1ace | #502, S | eabrook, | , Maryla | and 2070 | 06 |
| State Registrar | 31. Data filed (Month, Day, Year) JAN 2 7 2000 | 32. Ragistra | 's Signatura | lan | 1 | | | | | |

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Registrar

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There is work 10005 " S HAL

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| | | Decedent's Neme (First, Middle, La | st) | Cei | rtificate | e of L | <i>Jeath</i> | 2. Dete of De | Reg. No. | 3. | Time of Death |
|--|---------------------|--|--|--------------------------------------|---|-----------------------------|--|---------------------------------------|------------------------------------|--|--|
| Physici | | George P. | Poulos | | | | | Janua | rv 21. | 2 0 0 0 | 4:00A |
| /Medic | | 4e. Fecility Neme (If not institution, give | re street end number) | | | 41 | o. City, Town, or | | | | |
| | ••• | Mariner of I | Bethesda | | | | Bethe | sda | Mon | tgomer | У |
| Funeral Director | | 313 03 3014 | Sex 7. Age (In yr | s. last birthdey) Yrs. | If Under Monfhs | 1 Year Deys | If Under 24 Hrs Hours Min. | (Month, De | th by, Yeer) 2,1911 | 9. Birthplece Country) Gree | (Stete or Fore |
| r 28a-f show incilling at | 2 | Usuel Residence of Decedent 10a. State 10b. County Md Montgo | | City, Town or Lo | | na | | | | | nside City Lim |
| 28a-f | ecto | 10e. Sfreet end Number | 4 | | | | | | 40.000 41 | | MI les Z |
| 23a o | al Dir | 1111 Universit | y Blvd. We | st | 10f. Zip | 0902 | 2 | | 10g. Citizen of USA | wnat Country? | |
| "natural", or items idical Examiner in | by Funeral Director | 11. Maritel Status 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: | | Was Deced f Yes, speci 1 ☐ Yes 2 | | spenic Origin? (S n, Mexican, Puerl Specify: | pecify Yes or No o Ricen, etc.) | 14. Rac Ble Specif | ce - American Inck, White, etc. y: Whit | |
| - 95 | Completed | 15. Decedent's E. (Specify only highest gra Elementery/Secondery (0-12) | ducation ade completed) College (1-4or 5+) | (Give | lent's Usuel kind of work DO NOT use ur Gu | k done di e retired) | uring most of wor | rking | | usinass/industry | / |
| T, E | ပိ | 1.2 17. Fether's Neme (First, Middle, Last |) | | | | 18. Mother's Nar | ne (First Middle | | - | |
| nd Mental Hygiene. marked other than imatic event, the M | o Be | Pete Povlopoul | | | | | | iki Ko | | 10) | |
| I haein end Menial hygiene. tam 27 le marked other than other traumatic event, the M | To | 19e. informent's Neme/Reletionship (| Type, Print) | 19b. Mellin | ng Address | (Street e | nd Number or Ru | | | Stete, Zip Code | e) |
| naelth e am 27 le ther trat | | Pete Pavlos/Ner | hew | | | | urt, R | | | | |
| | | 20e. Method of Disposition | 20b | Place of Dispo | sition (Nem | ne of | 4 | Dete | 20c. Location | City or Town, S | |
| nt: If | | Marial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetlon 5 ☐ Other (Specification) | Removal from Stete Ga | ate of | Heav | ven | 1 | /25/00 | Silve: | r Spri | ng, Mc |
| Uepartment of Haeltr Important: If Itam 27 any Injury or other to once. | | 21. Signeture of unerel Service Licer | | 22 P1 | Name end | d Address | s of Fecility Rinald | i Fune | ral Se | rvice | |
| ysician fedical | | 23a. Part1. Enter the disease, or com shock, or heer feilure. List only | plicetions that caused the de one ceuse on each line. | eth. Do not ente | er the mode | of dying | Hamps , such es cardiec | or respiretory e | rresf, | App | roximete rval Between et end Deeth |
| aminer | | diseese or condition resulting in deeth) | | (or es e conseq | uence of): | DNIK | | | | | 472 |
| sit | edical Examiner | | b. COMA | | | | | | | M | HTMO |
| and al-trar | xan | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that inlitieted events | Due to | (or es a conseq | uence of): | | | | | | |
| sician burie | alE | cause. Enter Underlying Ceuse (Disease or Injury that Initiated events | c | | | | | | | i | |
| ding physician and se es the buriel-transit | | resulting in deeth) Lest | d | (or es e consequ | uence of): | | | | | | |
| atten for u | cian | D | | | | | | 1 | | | |
| signed by the attendin Id be datached for use | by Physician/N | Pert II. Other significent conditions of | ontributing to death but not re | esulting In the ur | nderlying ca | luse give | n in Pert I. | | Yee 2 No | ntribute to the | |
| s been 2 shou | Completed b | | | | | | | 24e. Wes | an autopsy ormed? | | e prior to ion of ceuse |
| ate hes page 2 | Eo | | | | | | | 1 🗆 | Yea 2 No | 1 ☐ Yes | 2 □ No |
| is certificate director, pag | Bec | 25. Wes case referred to medical exeminer? | | | | | 26. Plece of Dea | th (Check only | one) | | |
| 0 0 | 2 | 1 ☐ Yes 27 No | Hospitel: 1 ☐ Inpatienf 2 | ☐ ER/Outpetien | t 3 DO | A Othe | r: 4 Nursing H | ome 5 Resi | dence 8 Oth | er (Specify) | |
| or: After the | | 27. Menner of Deeth 1 Alatural 5 Pending 2 Accident Investigation | | 28b. Time of Injury | M 28 | Bc. Injury Work 1 🗆 Y | et | | how Injury occur | | |
| To the Funeral Director: After the completely filled in by the funeral | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Plece of Injury - At building, etc. (Spec | home, farm, stre | et, factory, | , office | | 28f. Location (City or To | Street end Numl wn, State) | per or Rural Rou | te Number, |
| • Funer | edical | 29a. Certifier (Check only one) Certifying Ph 2 Medical Exam | ysician: To the best of my kr niner: On the basia of examinend menner steted. | nowledge, deeth nation end/or Inv | occurred e estigetion, | t the time In my opi | e, dete end plece inlon, deeth occu | , and due to the rred et the time, | ceuse(s) and ma dete end plece, | anner as ateted. end due to the | ceuse(s) |
| Toth | Me | 29b. Signeture and title of certifier | Send MD | | 29c. | License B3 | number 92 VE AS | | 29d. Dete signe | d (Month, Dey, | 7000 7000 |
| | - 1 | 30. Name end eddress of person who | completed seven of death the | | | | | | | 749 | |

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| •• | - | | 8 | 0 |
|----|----|---|----|---|
| | 11 | 4 | 1 | 1 |
| | V | - | -3 | U |

| | 1. C | NSON ID ITEMS: #23 F Decedent's Name (First, Middla, | Last) | LUN-I | I LITE OF | | | 2. Date of De | | | ime of Death |
|--|-------------|--|--|---|---|--|--|---|--|--|-----------------------------|
| ictan | | Portia S. | Robinson | | | | | JAN. | 14, 2000 | Yaar D 15 | 01 PM |
| dical niner | | Facility Name (if not institution, | give street and num | | | | 4b. City, Town, or | | , | | |
| | F | PRINCE GEORGES | | | | | CHEVER | Charles and the second | PRIN | CE GEORG | GES |
| al or | 5 | 78-19-8708 Ial Residence of Decedent | 6. Sex 1 □ M 2 1 F | Age (in yrs. 2 | 6 Yrs. | If Under 1 Ye Months De | | | 8, 1973 | 9. Birthplace (S Country) West In | |
| | | . State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | 10d. fn: | sida City Limits |
| tor | | | | - | Washi | ngton, | D.C. | | | 128 | Yes 2 No |
| le o | 10e | . Street and Number | | | | 10f. Zip Cod | 0 | | 10g. Citizen of W | Vhat Country? | |
| al C | | 1238 44th Pla | ace S.E. | | | 20 | 019 | | West 1 | Indies | |
| by Funeral Director | | Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Date | es? Ki No | | Vas Decedent of Yes, specify C | of Hispanic Origin? (: luban, Mexican, Pue No Specify: | Specify Yes or No rto Rican, etc.) | Blac | a - American thook, White, etc. ::Black | lian, |
| Completed | E | 15. Decedent's (Specify only highest lamantary/Secondary (0-12) | | lor 5+) | (Give | OO NOT use re | ne during most of wo tired) | orking | | usinass/Industry | |
| | 17 | Father's Name (First, Middle, L | ast) | | 5 | ecretar | 2 | ma (First, Middla, | NIH Maidan Sumam | (6) | |
| Be | | Karl Carter | 2017 | | | | | H. Cart | | , | |
| P | 198 | a. Informant's Name/Ralationsh Jeffrey V. Rot | | sband | 19b. Mailin 1238 | | eet and Number or F | tural Routa Numb | | | _ |
| | 20a | . Method of Disposition | | 20b. F | Place of Dispo | sition (Name of | | Date | | City or Town, S | tate |
| | | 1 Donation 5 Other (Sp. | | ata (| cemetery, cran | natory or other | ial Park | 1/22/00 | Landove | | |
| | 21. | Signature of Funeral Service L | | | | | | | | L, IIu. | |
| | | V. +01 | 4 | M | 1 | | dress of Facility er S. Pop | | | 1/1 00 | 7/7 |
| | 23 | a. Part1. Enter the disease, or o shock, or heart failure. List o | complications that ca | used the deat | | | rlboro Pi dylng, such as cardia | | | Appr | 747 oximata |
| ĵ, | | shock, or heart failure. List o | only one cause on as | ch line. | | | | | | | val Between et and Death |
| | Imr | nediate Cause (Final ease or condition | | GU | NSHOT | WOUND O | F CHEST | | | | |
| | ras | ulting in death) | a | Due to (| or as a consaq | uenca of): | | | | | |
| ine | | | b. ——— | | | | | | | | |
| Examiner | Sec if a | quentially list conditions, ny, laading to immediata ise. Entar Underlying use (Disease or Injury | | Due to (| or as a conseq | uenca of): | | | | | |
| <u>e</u> | Cau | use. Entar Underlying use (Disease or Injury t initiated events | C | | | | | | | i | |
| edicai | res | ulting in death) Last | Z-c- | Due to (c | or as a consequ | uenca of): | | | | | |
| 2 | | Valency Lab | d | | | | | | | | |
| Physician/M | Part | tl. Other eignificant condition | ns contributing to dea | th but not res | ulting in the ur | nderlying cause | given in Part I. | 23b. Dld | tobacco uae cor | ntribute to the | ause of deat |
| hÿ | T. | | | | | | | 10 | Yee 2□ No | 3 Probably | 4 Unknow |
| | | | | | | | | 24a. Was | an autopsy rmed? | availabla | on of cause |
| ò | _ | | | | | | | | Yes 2□No | 1 Was | 2 No |
| þ | | | | | - H-5 | 11.21 141 | 26. Place of De | eath (Check only | ona) | | |
| e Completed by | | Was case referred to medical | | | KR/Outpatien | t 3□ DOA | Other: 4 Nursing | Home 5 ☐ Resi | denca 6 □Oth | er (Specify) | |
| o Be Completed by | | Was case referred to medical examiner? ↑CK as 2 □ No | Hospital: | patient 2 | CAD a Corbation | | -11 | 28d. Describe | how injury occur | | |
| To Be Completed by | 27. | examiner? ¶∭vas 2 No Manner of Death | 28a. Date of | Injury | 28b. Tima of | 28c. t | njury at Work? | | | | |
| To Be Completed by | 27. | examiner? X | 28a. Date of FOUND: | Injury Day Year) | 28b. Time of UNKNOW | NM | 1 ☐ Yes 2 X No | | JECT SHO | | 4- 81 6 |
| Certification: To Be Completed by | 27. | examiner? **Dota 2 No Manner of Death 1 Netural 5 Pending | 28a. Date of FOUND: | Injury Day Year) | 28b. Time of UNKNOW | N M 28c. t | 1 ☐ Yes 2 X No | 28f. Location (City or To | JECT SHO Street and Yumb wn, State) 123 GTON, DO | ger or Aural Rou 38 44th | PLACE, |
| Certification: To Be Completed by | 27. | examiner? \(\inc \) \(\frac{1}{2} \) \(\frac | 28a. Date of FOUND: | Injury Day Year) OO If Injury - At h g, atc. (Special HOME est of my knows of examine | 28b. Tima of UNKNOW ome, farm, stray) | eet, factory, offi | 1 ☐ Yes 2 X No ce s time, date and place | 28f. Location (City or To WASHIN | Street and Numb wn, State) 123 GTON, DC cause(s) and ma | per or Aural Rou 38 44th C. | |
| To Be Completed by | 27. | examiner? \(\frac{1}{2} \) \(\frac{1}{4} \) \(\frac{1} \) \(\frac{1}{4} \) \(\frac{1}{4} \) \(\frac{1}{4} \) \(\ | 28a. Date of FOUND 1 of be beed 28e. Placa of building Physician: To the beaming: On the background 1 of t | Injury Day Year) OO If Injury - At h g, atc. (Special HOME est of my knows of examine | 28b. Tima of UNKNOW ome, farm, stray) | eet, factory, offi | 1 ☐ Yes 2 X No ce s time, date and place | 28f. Location (City or To WASHIN | Street and Numb wn, State) 123 GTON, DC cause(s) and ma | anner as stated and dua to the c | cause(s) |
| edical Certification: To Be Completed by | 27. | examiner? Order Order | 28a. Date of FOUND 1 of be beed 28e. Placa of building Physician: To the beaming: On the background 1 of t | Injury Day Year) OO If Injury - At h g, atc. (Special HOME est of my knows of examine | 28b. Tima of UNKNOW ome, farm, stray) | eet, factory, office occurred at the restigation, In m | to Yes 2 No | 28f. Location (City or To WASHIN | Street and Numb wn, State) 12 GTON, DO cause(s) and ma date and place, | anner as stated and dua to the c | eause(s) Year) |

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| Dhustala | | 1. Decedant's Nam- | | | | | | | 2. Data of Dea | | V | 3. Tima of De |
|---|---|--|--|--|--|--|--|---|---|--|---|--|
| Physicia /Medica | - | Ber | mard | Joh | n | Ra | aley | | Januar | y 27, 2 | 000 | 7:554 |
| Examine | | 4a. Facility Name (# | | on, give street and Marylan | | ital | | 4b. City, Town, or Clinton | ocation of Death | , | | rge's |
| Funeral Director | | 5. Social Security N 578-03-30 | | 6. Sex 1 M 2□ | | In yrs. last birthda Yrs. | y) If Under 1 Yaar Months Days | | 8. Data of Birth (Month, Day Feb. 2 | | | laca (State or F |
| > | | Usual Residence of | | | | | | | Teu. Z | ,1300 | Mary | land |
| Shoy | _ | 10a. Stete | 10b. County | • | | Oc. City, Town or | | | | | 1 | 0d. Inside City |
| 289-1 | ecto | Maryland 10e. Street and Nun | | e George | 'S | CII | nton | | | | | 1 ☐ Yes 2 |
| 23a or | rai Di | 8600 Mik | | | | | 10f. Zip Code | 20735 | | | .S.A. | try? |
| - 8 | þ | 11. Marital Status 1 Never Marria 3 Widowed | | If Yes, | Decedant Event d Forces? as 2 No Give or Dates: | 1943— 1945 | 3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No | | pecify Yas or No- p Rican, etc.) | 14. Rac Blac Specify | a - Amaric ck, White, c : Wh | |
| ona. than "natu he Medica | Be Completed | (Special Special Speci | ify only highe | nt's Education ast grade complete Colleg | ed) ge (1-4or 5+) | | eedent's Usual Occu ve kind of work done . DO NOT use retire | pation during most of wor ed) | king | G.S Federa | .A. | lustry rernment |
| ent, | ပိ | 17. Fathar's Name (| First, Middle, | | | Gu | ard | 18. Mother's Nan | ne (First, Middle, I | | | CLIMICIN |
| ked c | To Be | Josep | | | ley | | | | | KNOWN) | , | |
| 7 is mar traumet | | 19a. Informant's Na Regina | me/Relations | ship (Type, Print) | fe) | 19b. Me 860 | lling Address (Street | tand Number or Runapiro Dri | | | Stete, Zip | code) ryland |
| icicion | | shock, or hear | t failure | r complications the conly one cause of | at caused the | | ntar tha mode of dyl | lexandria | | | | Approximete Intarvai Betwe |
| And physician and see as the burial-transif amiliar franchist | | shock, or hear Immediate Cause (f disease or condition resulting in deeth) Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in deeth) L | Final nditions, mediate dying njury | - | at caused then each line. | e death. Do not e | ntar tha mode of dyl | ng, such as cardiac | or respiratory arr | est, | | Approximete Intarvai Betwe |
| ledicai aminer | | Immediate Cause (f disease or conditior resulting in deeth) Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in deeth) L | Final nditions, mediate trying njury | 6. Cc | A Caused the neach line. | e death. Do not e | equence of): Port (equence of): equence of): equence of): | T FALCE HEART | or respiratory arr | est, | ntributs to | Approximate Interval Betwee Onset and Der |
| ledicai aminer | | Immediate Cause (f disease or conditior resulting in deeth) Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in deeth) L | Final nditions, mediate trying njury | 6. Cc | A Caused the neach line. | e death. Do not e | equence of): Port (equence of): equence of): equence of): | T FALCE HEART | or respiratory arr | est, | | Approximate Interval Betwee Onset and Der |
| ledicai aminer | | Immediate Cause (f disease or conditior resulting in deeth) Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in deeth) L | nditions, mediate hydrog njury ast | 6. Cc | A Caused the neach line. | e death. Do not e | equence of): | T FALCE HEART | or respiratory arr | obacco usa con ss 2 No | atributs to | Approximate Interval Betwee Onset and Derivative Conset and Deriva |
| ate has been signed by the attending physician and pege 2 should be detached for use as the burial-transif | completed by Physician/Medical Examiner | Immediate Cause (fidisease or condition resulting in deeth) Sequentially list conif any, leading to limicause. Enter Under Cause (Disease or it that initiated events resulting in deeth) L Part tl. Other signification. | nditions, mediate hydrog njury ast | 6. Cc | A Caused the neach line. | e death. Do not e | equence of): Port (equence of): equence of): equence of): | T FALCE HEART | Or respiratory arr | obacco usa con ss 2 No | ntributs to 3 Prob 24b. We ava | Approximate Interval Betwee Onset and Dei |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physiclan** Month Howard Lewis Ritchie, Sr. 5:32 p.m. 24, January 2000 /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing and Restorative Center Bowie Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□ F Months 215-10-7441 83 Yrs. Director March 6, 1916 Washington, D.C. Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Prince George's Maryland Bowie Director 1₺ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? à must be 12315 Kembridge Drive 20715 U.S.A. 12. Was Decedenf Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married b 1 Yes 2 No Specify: à Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Private Industry altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 should be 1 and Mental 3 marked Charles Ritchie Mary Ervin 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health ar important: If Item 27 is Howard Lewis Ritchie, Jr. - Son 12315 Kembridge Drive, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ₺ Burial 2 Cremation 3 Removal from State 1/28/00 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Fecility
Gasch's Funeral Home 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth shock, or heart fellure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 **Physician** RESPIRATORY FAILURE <1

Due to (or es a consequence of):

END-STAGE PROSTATE CANCER >1 /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** physician and s the buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lesf Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 ANO 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Waturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, streef, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated. 2 Medical Examinar: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner stated. 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) D-34525 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Road; #220; Bourie-M-20716 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

JAH 2 1 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 9 per fh G781 3/2/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Day Month **Physician** WILLIE DAVID SMITH **JANUARY** 20,2000 12:00pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 8. Date of Birth (Month, Day, Year) JULY 5,1945 If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1♥M 2□F 54 CLINTON, MD-NC Director 240-68-8000 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1♥ Yas 2□No Director 28a-f PRINCE GEORGES FORT WASHINGTON with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 8 10105 OLD FORT PLACE 20744 UNITED STATES Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 1 Yes 2 □ No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) Cotlege (1-4or 5+) POSTAL CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First Middle Maiden Surneme) å Pages 1 and 2 should be nent of Health and Mental RASSIE SMITH ANNIE COOPER 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) . nt of Health a If them 27 is or other tra MARY L. SMITH / WIFE 10105 OLD FORT PLACE, FORT WASHINGTON ,MD 20744 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Department of Important: If any Injury or MARYLAND VETERANS CEM. 1-27-00 CHELTENHAM, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Fecility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 unmers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): abstract in Box 68760. Physician/Medicai Due to (or as a consequence of): 980 signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. 25. Was case reterred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Division 1 Netural 5 Pending after death.

Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Place of thjury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide 24 hours a Hospital XIII Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie D25640 JANUARY 21,2000

State Registrar

DHMH 16 Ray 6/95

32 Registrar's Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KHOSROW DAVACHI

7503 SURRATTS RD. CLINTON,MD 20735

JAN 2 " 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 04152

| | | | Certific | ate of | Death | | Reg. No. | | 14132 |
|---|--|--------------------------------|---|-------------------------|---|--|---|--|--|
| lame (First, Middle, Last | | | | | | 2. Dete of De Month | eth Dev | Year | 3. Time of Death |
| lice Mary | Schmidt | | | | | Jan. | 20 | 2000 | 1:00 P.M |
| ne (If not institution, give | street and number) | | | | 4b. City, Town, or L | ocation of Deet | | unty of Deat | |
| n Convalesc | ent Cente | r | | | Crofton | | | ne Aru | |
| 7,02 | X 7. Age | 90 | Yrs. If Ur Mont | nder 1 Year ths Days | | 8. Date of Bir (Month, De Decemb | er 15, | 9. Birt | holece (State or Foreig untry) New York |
| te of Decedent | | 10c City To | own or Location | | | | | | 10d. Inside City Limit |
| d Prince G | eorge !s | Bowi | | | | | | | 1 Ves 2□N |
| Number S | eorge s | DOWL | | Zip Code | | | 10g Citizer | of What Co | untry? |
| iana Place | | | 1.0 | | 20715 | | | ed St | |
| us | 12. Wes Decedent I | Ever in U,S. | 13. Was Do | ecedent of | Hispanic Origin? (Spoen, Mexican, Puerto | ecify Yes or No | - 14. | Race - Ame | |
| Married 2 Married | Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | No | | specify Cut | | Rican, etc.) | | Black, White ecity: | White |
| 15. Decedent's Edu | cation | 16 | Sa. Decedent's I | Jsual Occu | pation | | 16b. Kind | of Business/ | industry |
| Specify only highest grad Secondery (0-12) | e completed) College (1-4or 5 | (+) | life. DO NO | T use retire | during most of work ed) | ang | | | |
| | 0 | | Secreta | ry | | | Dzu | ıs Fas | teners |
| me (First, Middle, Last) | | | | | 18. Mother's Nem | e (First, Middle | , Maiden Su | mama) | |
| eagher | | | | | Alice | Handra | han | | |
| s Name/Relationship (Ty | | | | | t end Number or Ru | | | | (ip Code) |
| ice Batvini | | 1 | | | lace Bowi | | | | |
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| f Funeral Service Licent | 60 11 | | 22. Nam | e and Addr | ess of Fecility | 1 II | | | |
| Wal I | i U UOD |) | | | Evans Fu apolis Rd | | | | 0715 |
| ter the diseese, or compl heart feilure. List only or | licetions that caused | the death. D | o not enter the | mode of dy | ing, such es cardiac | or respiratory e | rrest, | Lanu Z | Approximate |
| heart feilure. List only or | ne ceuse on each Ilr | 10. | | | | | | | Intervel Between Onset and Death |
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| gnificant conditions cor | ntributing to death bu | ut not resulting | a in the underlyi | na cause a | iven in Part I. | 23b. Did | tobacco ua | e contribute | to the cause of deat |
| \wedge | | | | | | | Yes 20 | | robably 4 Unkno |
| Deme | nta | | | | | | | | |
| | | | | | | | en eutopsy | | Were eutopsy findings eveilable prior to |
| | | | | | | | | | completion of cause of deeth? |
| | | | | | | 10 | Yes 2⊞1 | To | 1 ☐ Yes 2 ☐ No |
| eferred to medical | | | | | 26. Place of Dea | th (Check only | one) | | |
| 22 No | Hospitel: | nt 2□ER/ | Outpatient 3 | DOA | ther | ome 5 Res | | Other (Spe | city) |
| Deeth | 28a. Dete of Injui | | o. Time of | 28c. Inju | ury at | 28d. Describe | how injury o | ccurred | |
| 5 Pending Investigation | (MOIMI, De) | / I bail) | Injury M | | Yes 2 No | | | | |
| 6 Could not be determined | 28e. Plece of Injubulding, etc. | ury - At home, c. (Specify) | , farm, street, fa | ctory, office | | | (Street end N wn, State) | lumber or Ru | arel Route Number, |
| 1 Certifying Phys | sicisn: To the best of ner: On the basis of end menner sta | examinetion | ige, deeth occur and/or investige | rred et the t | ime, date and plece opinion, deeth occur | , and due to the rred et the time, | cause(s) en date and pla | d menner as aca, and due | stated. to the cause(s) |
| and title of certifier | 55 monitor 316 | | | 29c. Licen | se number | | 29d. Date s | igned (Mont | h, Day, Year) |
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State of Maryland / Department of Health and Mental Hygiene 00 04 153

| | Certificate of Death | | Reg. No. | 04133 |
|--|--|--|---------------------------------|--|
| | Decedent's Name (First, Middle, Last) | 2. Dete of Dea | | 3. Time of Death |
| Physician /Medical | James A. Semmig | 1 | 27 | 2000 045-3 |
| Examiner | 4e Facility Name (If not institution, give street end number) 4b. City, Town, | or Location of Death | 4c. County of | Deeth |
| | Carroll County General Hospital Westmi | | Carı | roll |
| Funeral Director | 5. Sociel Security Number 578-30-5280 G. Sex 7. Age (In yrs. last birthday) Fi Under 1 Year if Under 24 Fi Months TOD M 2 Fi 70 Yrs. Hours M Usual Residence of Decedent | fin. 8. Date of Birt (Month, De) Feb. 15 | , Year) , 1929 | D. Birthplace (State or Foreign Country) New Jersey |
| Jend H | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| with the Maryland a or 28s-f show be notified at | Md. Carroll Woodbine | | | 1 X Yes 2 □ No |
| r 28e-f | 10e. Street and Number 10f. Zip Code | | t0g. Citizen of Wh | at Country? |
| ms 23a or | 7024 Woodbine Road 21797 | | U.S.A. | |
| it, or terms 23s or 28s-fe term nor most be notified by Funeral Director | 11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Merried 3 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pty Yes 2 No Specify: 1 Yes 2 No Specify: | (Specify Yes or No- uerto Rican, etc.) | | American Indian, White, etc. white |
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| 8 0 | 17. Fether's Neme (First, Middle, Last) 18. Mother's I | Neme (First, Middle, | | |
| 0 | William G. Semmig Marg | aret C. H | andiboe | |
| To B | 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or | Rural Route Number | or, City or Town, St | ate, Zip Code) |
| om 27 I | Mary Semmig Berry/daughter 7024 Woodbine Rd., W | oodbine, | | |
| ury or other | 20a. Method of Disposition 1 | Feb. 3, | Alex., \ | |
| Important: If he eny injury or of once. | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility De Vol Funeral Ho 2222 Wisconsin A | | Wash. DC | 20007 |
| - | 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care spock, or heart failure. List only one cause on each line. | | | Approximate Interval Between |
| sician | | | | Onset and Death |
| ledical | Immediate Cause (Final disease or condition MYOCAZ DIAZ INFA | 42CT7 | ON | 2 14125. |
| aminer | Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFA Due to (or as a consequence of): CORONALM ARTER | | | 2 1100 |
| | - CORONARY ARTER | y D1 | SEASE | 10 4125, |
| burletransit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | , | |
| Wedle | Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | |
| for us | | 1 | | |
| igned by the ettendibe deteched for use by Physician/ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | bute to the cause of death? |
| y P | D1AB8725 | _ 10' | Yea 2□ No 3 | Probably 4 Unknown |
| should should | CHRONIC LUNG DISEASE | 24a. Wes | an autopsy med? | 24b. Were autopsy findings aveilable prior to completion of cause of death? |
| certificate has irector, page 2 3 Be Comp | | 101 | res 2000 | 1 ☐ Yes 2 ☐ No |
| o o o | | Death (Check only o | | |
| I director | examiner? | a Home 5 ☐ Resid | | (Specify) |
| 23 50 | 27. Manner of Deeth 1 Veletural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Dete of Injury 28b. Time of Injury Work? 1 Yes 2 No | | now injury occurred | 1.4.1.2.44 |
| To the Funeral Director: After to completely filled in by the funeral Medical Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) | 28f. Location (5 City or Tox | Street and Number yn, State) | or Rural Route Number, |
| pletely fille edical C | 29e. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth of any manner steted. | | | |
| To the comp | 29b. Signature and the of curtifier 29c. License number | | 29d. Date signed (| Montty Oay, Year) |
| | 1 Da520 | 2 | 1/27 | 100. |
| 2 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & MERG. | DSPT | GENIL | ItOSP. |
| State | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | |
| Registrar | FFB 10 2000 Server G. Source | | | |

ORIGINAL

DHMH 16 Ray 6/95

4 . 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1 Decedent's Name (First Middle I ast) 2 Date of Death Month **Physician** Sheppard Herber 6:26 AM HUQUSTUS 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Sex Birthplace (State or Foreign Country) **Funeral** 1<u>⊠</u> M 2□ F Months Yrs. 57 577-56-4503 Director April 27,1942 S.C. Usual Residence of Decedent the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Prince Georges Director Landover 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7426 Bell Haven Court Funeral 20785 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiena. Is marked other than "natural", or its 1 ☐ Yas 21 No If Yes, Give Yaar or Datas: 1 Nevar Marriad 2 X Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Bailing Operator other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 70 Emily Sheppard Herbert L. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7426 Bell Haven Court 19e. Informent's Name/Relationship (Type, Print) permit. Peges 1 end 2 st Department of Health end Important: If item 27 Is n Shirley Sheppard/wife 20785 Landover, MD. 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State any injury or o 1/28/00 Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Hodges & Edwards F.H. nic 20746 3910 Silver Hill RD. Suitland, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlac or respiratory arrest, enock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CARDIOPYLMONARY ARREST Examiner Due to (or es a consequence of): Examiner DUSSIBLE ACUTE MYDIARDIAL INFARCE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-tran pue Due to (or es e consequence of): BRADY (ARDIA physician certificata be Physician/Medical Dua to (or as a consequance of): the 80 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 4 Unknown 6 1 Yes 2 No 3 Probably DIABELES MELLIATHS þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy parformed? Completed hes 20 No 1 Yas 1 ☐ Yes 2 ☐ No certificata 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ≥ Yes 2 No 10 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending Investigation Maturel of attending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide 24 hours 1 Cartifying Phyalctan: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To the To the 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 2000 Kimateran and D50680 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) PGHOSPITAL. 3001 HOSPITAL DPIVE CHEVERLY MD 20785 MACAHAM XIINA 32. Registrar's Signatura State Registrar

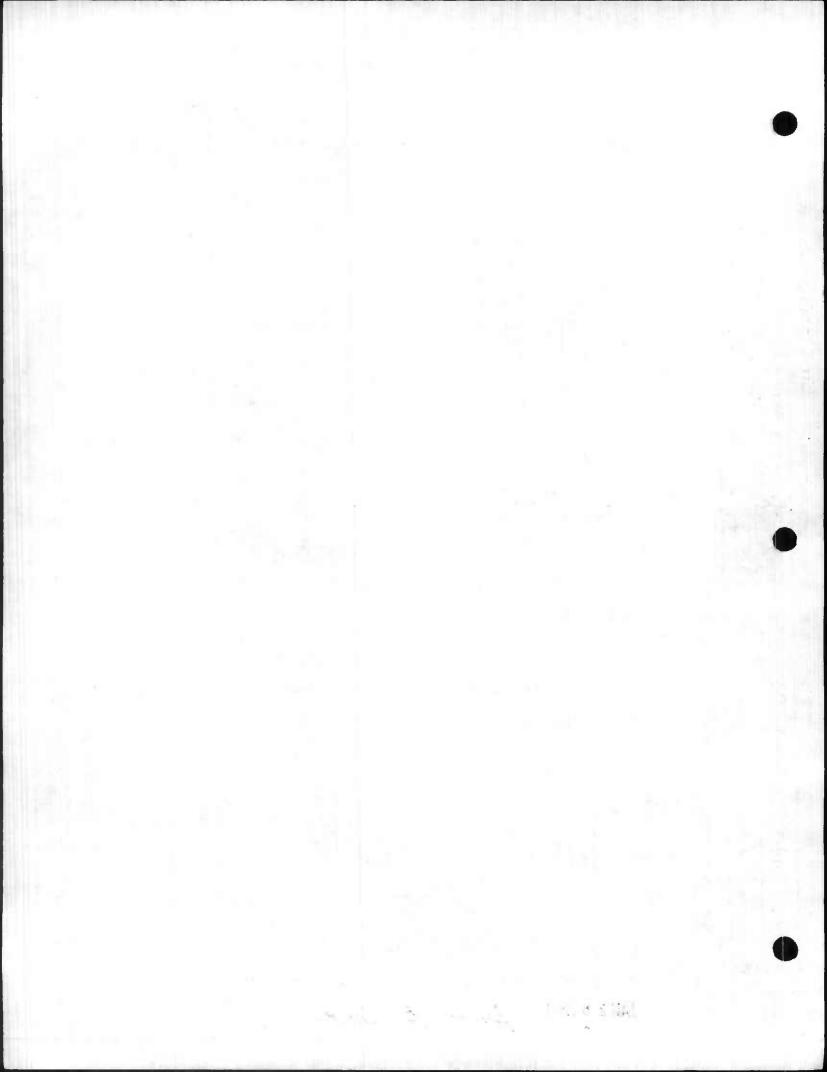
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| ian ical | | | le Swi | | | | | | Janua | | | 2000 | 2:25AM |
| ner | 4a Facility Name | | | | | | | | or Location of Da | | c. County | | |
| | 5. Social Securit | | rylano | Hosp: | ital In yrs. last bi | irthday) If Und | ar 1 Yaar | | Hrs. 8 Date of F | lirth | | Q Ristholage | orges (State or Foreign |
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| | 11. Marital Statu | | reet, | IV • L • | er in U.S. | | | | ? (Specify Yas or t | - | | - Amarican i | |
| | 1 XNavar M | arried 2 Ma | Armad 1 5 | med Forcas? XYas 2 ☐ No res, Giva ar or Datas: | | | | Specify: | ? (Specify Yas or ? uarto Rican, atc.) | | Specify: | k, White, etc. : Black | |
| | 16. | 15. Deceda | nt's Education | - Inta et) | 168 | Decedent's Us | uai Occup | ation | undina | 16b. | Kind of Bu | sinass/Indust | |
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| 1 | 21. Signature of | n 5 □ Other (: | | | kesur | rectio | | | 1/27/0 Hodges | | | ton, | |
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| | Decedent's Nama (First, Middle, Last) | | | ificate of | | , , | , No. 0 (| 04156 |
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| ner | 4a Facility Nama (If not institution, give s 5. Social Security Number 6. Sex 213-58-5135 Usual Residence of Decedent | _ | th Arun Hos s. last birthday) Yrs. | HUnder 1 Year Months Days | If Under 24 Hrs. | 8. Data of Birth (Month, Day, 1) | Ac. County of Paris | 9. Birthplace (State or Foraign Country) (orth Carolin |
| 2 | 10a. Steta 10b. County | | city, Town or Loca | | | | | 10d. Inside City Limits 1 No Yes 2 No |
| Director | Md. Anne Art 10e. Street and Number | undel | | Crofto | n | 100 | . Citizen of W | |
| | 1727 Fillmore Co | ourt | | 21 | 114 | | TI | SA |
| by runeral | | I2. Was Decedent Ever in l Armed Forces? 1 ☐ Yes 2X No If Yas, Giva Year or Detas: | | | Hispanic Origin? (Specian, Mexican, Puarto R | city Yas or No- ican, atc.) | 14. Race | American Indian, |
| | 15. Decedent's Educ (Specify only highast grade Elementary/Secondary (0-12) | cation completed) College (1-4or 5+) | (Giva kı lifa. Di | nt's Usual Occup ind of work dona O NOT usa retire | during most of working) | 9 | | rgo Inc. |
| | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nama | (First, Middle, Ma | aiden Sumame | |
| | Stephen L. Kelet | | 40h 14-11 | Address (Classes | Grace Le | | | Parte Tie Codel |
| | 19a. Informant's Name/Reletionship (Ty) Jay Thomas Smith | | | | re Ct. C: | | | |
| | 20a. Mathod of Disposition 1 2 Burial 2 Cremetion 3 R. 4 Donation 5 Othar (Specify) | emoval from Stata R | Place of Disposicematary, crematary | tion (Neme of atory or other pla Ction | | Data 20 | c. Location - (| City or Town, Stata |
| | 23a. Part1. Entar tha disease, or complications, or heart failure. List only on Immediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disease or injury that initiated evants resulting in death) Last | Chronic C Alviano Due to (| or as a consequence or as | twe lence of): nence of): ence of): | Pulmone Avshi | y Do | Selse | Onset and Death |
| ı | | | | | | 1 🗆 Yee | 2 □ No | 3 Probably 4 Nunknown |
| | | | | | | 24a. Was an performe | autopsy ed? | 24b. Were autopsy findings available prior to complation of causa of death? |
| ŀ | or W | | | | | 1 ☐ Yas | | 1 ☐ Yas 2 ② No |
| ı | 25. Was case referred to medicel examinar? 1 Yes 2 No | ospital: 1 Inpatient 2 D | ☐ ER/Outpatient | 3□ DOA OII | 26. Place of Death her: 4 ☐ Nursing Hom | | | r (Snaciby) |
| | 27. Manner of Death 1 Patural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inju Wo | | Bd. Describe how | | |
| ĺ | 3 Suicide 6 Could not be detarmined | 28e. Place of Injury - At I building, atc. (Spec | homa, farm, stree ify) | et, factory, office | 2 | Bf. Location (Stre City or Town, | | er or Rural Routa Number, |
| l | / | | owledge death (| | ima, data and place, a | | | |
| | 29a. Certifier (Check only one) 1 Certifying Physical Examin | ician: To the best of my kn er: On the basis of axamin and manner stated. | | | | d at the time, dat | a and place, e | nd dua to tha ceusa(s) |
| medical certification. | (Check only 2 Medical Examin | er: On the basis of axamin and manner stated. | ation and/or inva | stigation, in my o | opinion, death occurre | 290 | d. Data signed | (Month, Day, Year) W 25, 2000 Clex III N.D. |

Registrar

JAN 2 8 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth 2:30 P.M. SPEARS WALTER 12000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Prince GEORGES MEDICAL CENTER hevery If Under 24 Hrs. Mc Prince GEURGE 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 100M 2□ F Months Deys Hours Min GREENS BORUNG YNAVAILABRYTS. UNKNOWN UNAUNITABLE Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits RINCE 1 Yes 2 No G.EUK9e GNAUAILABLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 454 4NAVAILABLE UNAVAILABLE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 15 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: B/ACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired) ServiLe PUBLIC Elementery/Secondery (0-12) College (1-4or 5+) METRO CONSTUCTION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) WILLIAM ANNIE BELLE PORTER SPEAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2425 18th St. N.E. Wash. 20b. Place of Disposition (Name of Date Cemetery, cremetery or other place) CHESAPEAKE GEMATORY 2-5-00 MILLER SHEILA D.C. 20018 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State BELTSUILLE, Md 5 □ Other (Specify) 4 Donetion 22. Name and Address of Facility STERUNG FUNERAL 20019 SERVICE 1601 KENILWORTH AUE NIE WINSH. D.C of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest unt only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Cung Cancer Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Dfd tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Junkhown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 JN6 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 LNO 1 Inpatient 2 DER/Outpatient 3 DOA 28c. fnjury at Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of fnjury (Month, Day Year) 1 Naturei 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

physician and the burief-transit 60 950 P.O. signed by t Division of Vital Records, pege 2 s 188 certificate or Attending Physician: After this Iuneral after death.

Physician/Medicai by Completed Be O_ Certification:

Medical

Examiner 24 hours a

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or herrs 23s or 28s-f traumatic event, the Medical Examiner must be notifie

Hygiene.

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Physician

/Medical Examiner

Maryland 21215-0020

Baltimore,

/Medical

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Be

4 Homicide 29a. Certifier (Check only one)

6 ☐ Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted.

29b. Signature and tigle of certif

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

HAL ON CHEVERLY

Registrar

31. Dete filed (Month, Day, Year)

JAN 2 8 2000

32. Registrar's Signature

DHMH 16 Rev 6/95

Hospital

within 2 To the

USS 5 5 548.

Registrar

State

31. Dete filed (Month, Dey, Year)
FEB 0 2 2000

THEODORE MIKE

32, Registrer's Signetura

111 Penn Street, Baltimore, Maryland 21201

FEB 9 2 2000 Street 13 Francis

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Physician | 1. Decedent's Nan | ne (First, Middle, | Last) | | | | | | | 2. Dete of Deat Month | | Year | 3. Time of Deat |
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| /Medical | | | andor | Α. | | Taka | | | | January | | | 8:00A.M |
| Examiner | 4a Facility Name (| Chalford | | mber) | | | | 46. City, Too Bowi | | cation of Death | 4c. County o | | eorge's |
| Funeral Director | 5. Social Security I 719 01 2 | | Sex 1☐M 2☐F | 7. Age (In y | rs. last birtho 87 Yrs | Months | Deys | Hours | 24 Hrs. Min. | 8. Dele of Birth (Month, Day, August | Year) 24,1912 | 9. Birthp Coun Hun | lece (State or Foreign) gary |
| | Usual Residence of | 10b. County | | 100 | City, Town o | or Location | | | | | | 14 | 0d. Inside City Lin |
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| ral or | 5. Social Security 236-22-5 | Number | 6. Sex ₩ 2 □ F | 7. Age (In yr. | rs. last birthdey, Yrs. |) If Undar 1 Months | Yaar Deys | If Under Hours | 24 Hrs. Min. | 8. Date of Bird (Month, De May 24 | | | pleca (Stete or Fon |
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 6 2

| | | Certificate of Death Reg. No. | | | | | | | | | | |
|---|--|---|--|--|--|-----|-------------------------------------|---|--|------------------|---|--|
| Physician /Medical | Decedent's Name (First, Middle, L. Eleanor | Marie | Thornton | | | | | 2. Date of Death January 22, 200 | |) ÖÖr | 3. Time of Death 10:50PM | |
| Examiner | 4a Facility Neme (If not institution, give street and number) Southern Maryland Hospital | | | 4b. City, Town, or Clinto | | | | | | | orge's | |
| Funeral Director | 579-03-0062 | Sex 1 | 7. Age (In yrs. last birthday) If Under 1 Year Months Days | | | | 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) May 25,1917 9. Birthplace (State or Foreign Country) Washington IX | | | | |
| with the Maryland a or 2844 show the notified at | Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Morningside 1□Yes 2♥No | | | | | | | | | | | |
| O ther death with the Mai w Hems 23s or 28s-1's niner must be notified Funeral Director | 10e. Street and Number 4115 Maple Road 10f. Zip Code 20746 | | | | | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11215-0020 within 72 hours after death ane. than "natural", or frome 23 to the Medical Estimate must | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: | J,S. 13. | Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica □ Yes ② Specify: | | | | cify Yes or No- Rican, etc.) | Yes or No- in, etc.) 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 72 ho | | 15. Decedent's Education (Specify only highest grade completed) | | 6a. Decedent's Usuef Occupation (Give kind of work done during most of working | | | | | 16b. Kind of Business/Industry | | | |
| | Elementery/Secondery (0-12) 9th | Elementery/Secondery (0-12) College (1-4or 5+) | | | (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper | | | | | Retail | | |
| be filed had had had had had had had had had ha | 17. Father's Name (First, Middle, Las | | | | | | | (First, Middle, Maiden Sumame) | | | | |
| faryland 2 2 should be filed end Mental Hygi is marked other surmatic event, To Be Cc | Patrick Fitzpatrick | | | Mary | | | | Harney | | | | |
| Baltimore, Marylis permit. Peges 1 and 2 should Department of Heelih and Mer Important: if Hem 27 is marke any injury or other traumatic ance. To | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, 2 Kathy Thornton (Daughter-in-law) 9026 Holly Avenue Waldorf, Maryland | | | | | | | | | | | |
| | 1 X Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) | | | of Disposition (Name of tetry, crematory or other place) Jan. 25, 25, 2000 ar Hill Cemetery 2000 | | | | 2000 | Suitland, Maryland | | | |
| Ball permit Depart Import | 21. Signature of Furnaria Service Licensee 22. Name and Address of Facility Lee Funeral 6633 Old Alexandria Ferry R | | | | | | | | | | | |
| Physician | 23e. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death | | | | | | | | | Interval Between | | |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of): | | | | | | 1 | 2 days | | | | |
| . BOX 68/60, deeth certificate be executed e attending physician and d for use as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequenca of): d. | | | | | | | | | | | |
| P.O. BO) tel the deeth ce d by the attend elached for us, Physician | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | 23b. Did tobacco use contribute to the cause of death | | | | |
| | Congestive heart toulure | | | | | | | 1 Yes 2 No 3 Probably 4 Unkn | | | | |
| s been s 2 should | Congestive heart Loulus Parkinson's Syndrome | | | Myselfe. | | | | 24a. Was as perform | performed? avail com | | ere autopsy findings ailable prior to mpletion of cause death? | |
| | Bern Aller | | | | | | | 1 ☐ Ye | 1 ☐ Yes 2Ñ No | | N/A ⊇Yes 2□No | |
| To the Hospital or Attanding Physician: The within 24 hours attendeath. To the Funeral Director, After this certificate completely filled in by the Luneral director, pag. Medical Certification: To Be Co. | 25. Was case referred to medicel 26. Place of Death (Check only one) | | | | | | | | | | | |
| | 1 Yes 20000 27. Manner of Deeth 1 200 Natural 5 Panding | | | | | | | | (y) | | | |
| | 2 Accident investigation 3 Suicide 6 Could not to determined | 9 One Place of Indian. At home form about feeting office. | | | | | | | er or Rura | al Route Number, | | |
| | 29a. Certifier (Check only one) | | | | | | | | | | | |
| To the within To the compl | 29b. Signeture and the of certifier MD. | | | | | 270 | 29d, Dete signed (Month, Day, Year) | | | | | |
| (0) | Deorge 15 | nen M · D | • | , Print) | 89 | 26 | tox | and | ld R | 373 | 160) | |
| State Registrar | 31. Date filed Month, Dev. Year) | 32. Registrar's Sign | eture | day | | | - | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

| thygiene. The Medica Examiner near 12 a or 28e-f show and the Medical Examiner near 12 a or 28e-f show and the Medical Examiner near 12 and 1 | al er | JOHN OSCA As Espility Name (# pot lectitude | | | | | | | | | | |
|--|--|---|--|---|-----------------------------|---|-------------------------|---|--|---|--|--------------------------------|
| Funerai Director | | 4a Espility Nama /// not hotifution | | | | | | | 2. Date of De Month Januar | y 28,20 | Year | ime of Death 20 a.m. |
| Director | | | n, <i>give street and</i> nu | | | | | | Location of Deat | h 4c. County | of Death | |
| Director | | Circle Manor | | | | | | Kensin | 0 | Montg | | |
| how | | 5. Social Security Number 224–38–6501 | 6. Sex 10CHM 2□ F | 7. Age (In yrs. la 65 | st birthday) Yrs. | If Under Months | Deys | Hours Mir | | th ly, <i>Year)</i> -34 | 9. Birthplace (S Country) Horry C | |
| 요 프 | - | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or L | ncation | | | | | 10d Inc | ide City Limits |
| 2 2 2 | 5 | | | | | on D.C | 1 | | | | | Yes 2 No |
| E E | 20 | 10e. Street and Number | | | | 10f. Zip | | | | 10g. Citizen of | Mhat Country? | |
| 23a or | | 2502 Hamlin S | Street, NI | Ξ | | TOI. ZIP | Code | 20018 | | USA | | |
| al', or teme 23a or 28a-f s Examiner must be notified by Funeral Director | 2 | 11. Maritel Slelus 1 □ Never Married 2 □ Mar 3 □ Widowed 🏕 ☑ Divorced | Armed F | 2 No | | Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuben, Mexican, Puerto Rican, etc. □ Yes 2 | | | Specify Yes or No rto Rican, etc.) | 14. Race - American Indian Black, While, etc.) Specify: Black | | |
| your, the Mod called North the Completed by | pleted | 15. Deceder (Specify only highe Elementary/Secondary (0-12) | it's Education st grade completed | | 16a. Dece (Give life. | dent's Usua kind of wor DO NOT us | l Occup k done | eation during most of w | orking | 16b. Kind of B | usiness/industry | |
| | E | 12 | College | (1-4or 5+) | Bus | siness | Ow | ner - Se | 1f-Emplo | yed H | otel | |
| 2 4 | | 17. Father's Name <i>(First, Middle,</i> Alton Gore | 7,50 | | | | | | ame <i>(First, Middl</i> e Hickman | , Maiden Suman | 10) | |
| T le | | 19e. Informant's Neme/Relations Leila Thompson | | n/Niece | | | | | NE, Was | | | |
| y or other | | 20e. Method of Disposition 1 ☐ Burlai 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S | | State | netery, cre | osition (Nam matory or of | ther plac | | Date -31-00 | 20c. Location - | City or Town, Sta | ate |
| Important: If It any injury or o | Ì | 21. Signature of Funeral Service | | 110 | 7 2 | 2. Neme en | d Addre | ss of Fecility | Strick] Camp Sp | | eral Ser | |
| sician edical miner | | 23a. Pakt. Enter the disease, or shock, or heert felture. List firmediete Cause (Final disease or condition resulting in death) | complications that only one cause on a. | Koma | Do not en | ter the mode | | | | | Appro | eximate al Between t and Death |
| in and detransit | uner | | b | Due to (or | as a conse | quence of): | | | | | 0 | |
| physician and the burletransit | cal Exal | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | С | | | quence of): | | | | | | |
| 2 4 | וש | resulting in death) Lest | d | Due to (or o | es e consec | quence or): | | | | | | |
| e atte | 200 | Pert II. Other significant condition | ons contributing to d | leath but not result | ing in the u | inderlylna ci | ause giv | ren in Part I. | 23b. Did | tobacco usa co | ntribute to the ca | euse of death? |
| igned by the attending be detached for use a by Physician/M | y ruy | | | | | | | | 10 | Yes 20 No | 3 Probably | 4 Unknown |
| 2 should | ubieted | | | | | | | | 24a. Was | an autopsy ormed? | 24b. Were aut available completic of death? | prior to on of cause |
| cate ha | | | | | | | | | 10 | Yes 2 No | 1 🗆 Yas | 2□ No |
| rector, pag | | 25. Was case referred to medice examiner? | | | | | la | | eath (Check only | one) | | |
| 는 I O | | 1 ☐ Yes 2 No | | | R/Outpatie | | | 4 Nursing | Home 5 Resi | | | |
| After | a cons | 27. Manner of Deeth 1 Natural 5 Pendir 2 AccidenI Investi | gation | of Injury oth, Day Year) | 8b. Time o Injury | M 2 | 8c. Injur Wor 1 🗆 | yat rk? Yes 2 □ No | 28d. Describe | how injury occur | red | |
| al Director: After tied in by the funeral | THE STATE OF THE S | 3 Suicide 6 Could 4 Homicide determ | ined 200. Flace | e of fnjury - At hon ling, etc. (Specify) | ne, ferm, st | reet, factory | , office | | 28f. Location (City or To | Street and Numb wn, State) | per or Rural Route | Number, |
| To the Funeral Director: completely filled in by the Medical Certifical | | 29e. Certifier (Check only one) (Check only one) | ng Physician: To the Examiner: On the band man | e best of my know easis of examination oner stated. | edge, deat on and/or in | h occurred a | at the tin | ne, date and place plnion, deeth occ | e, and due to the curred el lhe time, | cause(s) and mo | anner as ststed. and due to the ca | iuse(s) |
| To the | | 29b. Signeture and title of certifie | -/- | m | K | 29c | Licens 34(| e number | | 29d. Date signe | d (Month, Day, Y | ear) |
| 3) | | 30. Name and address of person The Anne and address of person 31. Dete filed (Month, Day, Year) | who completed cau | se of deeth (Item : | 372 | Print) | RRA | AGOTA | NF KEI | VSING- | TONMI | 20895 |

State Registrar

JAN 2 8 2000

32. Registrer's Signeture

DHMH 16 Ray 6/95

165 - 19A

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#8 PER K.B. G782 4-20-2000 JAB Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Year **Physician** BOL 29 2000 13:30 JANUARY /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL If Under 1 Year 5. Social Security Number 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 8. Dete of Birth (Month, Day, Year) Unknown Hours Months Yrs. Director Usual Residence of Decedent 10d. Inside City Limita 10a State 10b. County 10c. City. Town or Location show 1 Yes 2 No Director Himor 288-4 10e. Street and Number 1339 10f. Zip Code 10g. Citizen of What Country? "natural", or heme 23s or 2123 Funeral nwood American Indien 12. Was Decedent Armed Forces 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) edent Ever in U,S. 11 Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No 1 Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementary/Secrindary (0-12) College (1-4pr 5+) NIA 14 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumame) 8 Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve 1au 19 404en 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 21334 Omachile 20b. Place of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, Stete 3 ☐Removel from State 1 Burial 2 Cremation 4 Donation 5 Dother (Specify) DISpose 21. Signeture of Funeral Service Licensee -600N. Wolfest 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or have feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 04 WEEKS a PULMONARY HYPERTENSION Examiner Due to (or as e consequence of) Examine 04 WEEKS ician and burlal-transit b CONGENITAL DIAPHRASMATIC HERNIA Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initreled events resulting in death) Last Due to (or es a consequence of) physician s the burlal 04 WEEKS PULMONARY HYPOPLASIA Physician/Medical Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown signed bedet by Certification: To Be Completed

The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. or Attending Physician: this funeral After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0020

| | | | | 24e. Wes en autopsy performed? | 24b. Wera autopsy findings available prior to completion of cause of death? |
|--|------------------------------------|-----------------------------|---------------------------------|--|--|
| | | | | 1 Yes 2 □ No | 1 ☐ Yes 2 No |
| 25. Wes case referred to medical | | | 26. Placa of Dea | ath (Chack only one) | A CHARLEST AND |
| examiner? | Hospital: | utpatient 3 DOA | Other: 4 Nursing H | lome 5 Residance 6 □Ott | ner (Specify) |
| 27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | | jury at ork? ☐ Yes 2 ☐ No | 28d. Describe how Injury occu | rred |
| 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmIned | 28e. Place of Injury - At home, fa | arm, street, fectory, offic | 6 | 28f. Location (Street and Num. City or Town, State) | ber or Rurel Route Number, |

29a, Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner stated.

DØ\$52991

29b. Signature end title of certifie Ame Ewatrel mo 29c. License number 29d. Date signed (Month, Day, Year)

January 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS LUSPITAL, BALTMORE, M ARYLAND

State Registrar

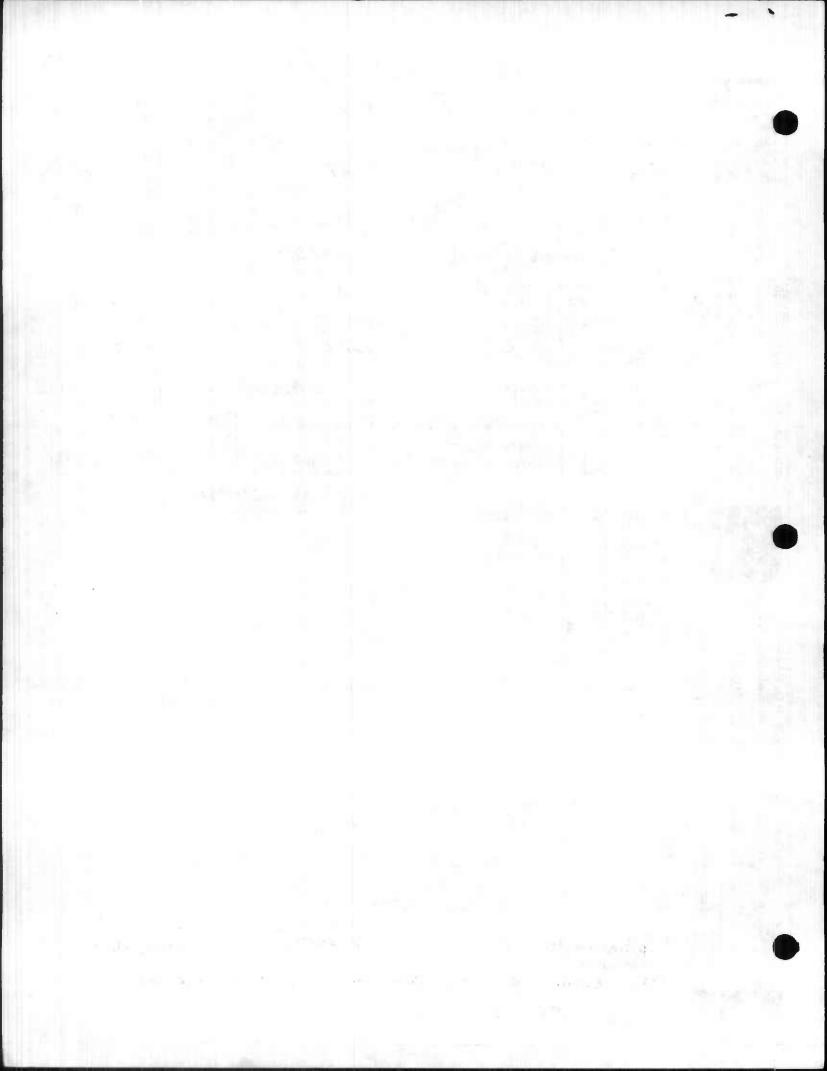
Medical

2 8 2000

JOANNE E. NATALE MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth CATHERINE VORCK 22, 2000 January 8:15 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1828 North Forest Court Crofton Anne Arundel 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 M 25F 204 16 8356 74 Yrs. Oct. 16,1925 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes KNO Crofton Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1828 North Forest Court Apt. C 21114 United States 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Ina Emma O'Neil Frank Nesbit Fairley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynn McCawley 1614 Dryden Way Crofton Maryland 21114 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20c. Location - City or Town, State 20a. Method of Disposition 26, Date 2000 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road, Bowie, MD 20715 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Yes No 27. Manner of Deeth I S Natural 2 A Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

: /Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

with the Maryland r 28a-f show

permit. Pages 1 end 2 should be filed within 72 hours after death with: Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 3 and hijury or other traumatic event, the Medical Exerciter must be in page.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be

attending physician and for use as the buriel-tran page 2 s funeral director.

10

Certification:

3 Suicide

29a. Certifier

29b. Signature

4 ☐ Homicide

(Check only one)

requires that the death certificate be exect signed by the a peen has cartificate or Attending Physician: this after death. Director: Aft filled in by 24 hours a Hospital within 2

Division of Vital Records, P.O. Box 68760,

Medical the 0

Registra

5 Pending

investigation 6 ☐ Could not be determined

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Clinton, W

31. Date filed (Month, Day, Year) JAN 2 7 2000

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

JAN 2 7 2000

Kanadayasis r. water

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** India Wallace January 19, 2000 8:30am /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sax **Funeral** 1□M 2MF Months Days Hours 577-58-6767 61 Oct. 6, 1938 Washington, D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County or 28a-f show 1 Yes 2 No Maryland Prince George's Cheverly Directo the 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? ms 23a or 6695 Old Landover Rd. 20785 United States Funeral filed within 72 hours aftar death Was Dacedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. "natural", or items 12. Wes Decedent Evar in U,S. Armed Forcas? 11. Meritel Stetus I ☐ Yes 2√ No If Yes, Give 1 Never Merried 2 Married Specify: Black 1 Yas 2 No Specify by 3 ☐ Widowed 4 ₺ Divorced Yaer or Detes Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Homemaker Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health end Mental William O. Samuels Thelma Lyles 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Neme/Reletionship (Type, Print) Health tem 27 is Anthony D. Wallace/Son 608-60th Pl. Fairmont Heights, Md. or other t 20743 20b. Pleca of Disposition (Name of camatery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ₺ Burlal 2 Cremetion 3 Removel from Stete Depertment of Important: If any injury or page. Lincoln Cemetery 1/25/00 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Fecility Alexander S. Pope Funeral Homes 21. Signeture of Funerel Service Licansee 5538 Marlboro Pike/Forestville, Md. 11085 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onsat and Deeth Immediate Cause (Final disaasa or condition resulting in death) # Examiner physician and s the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequenca of) attanding p been signed by the should be detached Pertit. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Was an eutopsy parformed? certificete has t lirector, page 2 s

Physician /Medical Examiner

5 1/4

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificata be executed

Completed Be Certification: To

1 Yes 2 No

27. Manner of Deeth

1/X Netural

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homicide

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not ba determined

Hospital:

12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Proce of Death (Check only one)

1 ☐ Yes 2 ☐ No

2 1 No 1 Yes

seems a Cente b. Is see bel

24b. Were eutopsy findings avellable prior to complation of cause of death?

1 ☐ Yes 2 ☐ No

Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated.

28c. Injury et Work?

29b. Signatura and titla of certifier

M-0,

29c. Licansa number D13987 29d. Date signed (Month, Dey, Year)

and eddress of parson who completed cause of deeth (Item 23e) (Type, Print)

S. S/DH FASWINDER 2525

32. Registrar's Signeture

State Registrar

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Hospital or Attending Physician: 24 hours eftar daath. Funeral Director: After this certifice

To the Hospital o within 24 hours eff To the Funeral DI completely filled in

funeral

Director:

Fig. 12-3 (199-15)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Neme (First, Middle, Las | | Certificate of | | Reg. No. Dete of Deeth Month Dev | 3. Time of Death |
|--|--|--|--|--|--|--|
| Physician /Medical | JOSEPH LEE | WILLIAMS | | Ja | anuary 16, 2 | 2000 1:19 P.M. |
| Examiner | 4e Facility Neme (If not institution, give | | | 4b. City, Town, or Locat | | nty of Deeth |
| | WASHINGTON ADVEN | | | TAKOMA PARK | | GOMERY |
| Funeral Director | 5. Social Security Number 578-56-8393 Usual Residence of Decedent | 7. Age (In yrs. I M 2□ F 68 | Months Dave | s Hours Min. | Dete of Birth (Mooth, Dey, Year) Oril 13 1931 | 9. Birthplece (State or Foreign Country) N.C. |
| with the Maryland a or 28a-f show be northed at | 10a. Stete 10b. County | 10c. City | , Town or Location | | | 10d. Inside City Limits |
| 28a-fah | Md. Prince Ge | orge's C | Colmar Manor | | | 1 X Yes 2 No |
| or 28 | 10e. Street end Number | | 10f. Zip Code | | 10g. Citizen o | of Whet Country? |
| 23.8 | 4315 Lawrence S | treet | | 722 | | ted States |
| al, or items 23s or 28s-fs Cvantoer must be northed by Funeral Director | 11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: | S. 13. Was Decedent of If Yes, specify Cu | Hispenic Origin? (Specification, Mexican, Puerto Ricon, Specify: | y Yes or No- an, etc.) 14. R 8 | leca - American Indian, leck, White, etc. |
| | 15. Decedent's Ed | ucation | 16a. Decedent's Usuel Occu | upetion | 16b. Kind of | Business/Industry |
| ygiene. Ner then "neturn it, the Medical Completed | (Specify only highest gred Elementery/Secondary (0-12) | College (1-4or 5+) | | | Dottes | 7 |
| ther the | 12th | | Gas Station | 1 | | |
| Be very | 17. Fether's Neme (First, Middle, Last) | | | | | eme) |
| To To | Earl William | | | | | |
| ls m | 19e. Informent's Name/Reletionship (T | | | | | |
| ther the | Joseph L. Williams 20e. Method of Disposition | | | | | |
| nent of ant: If its ury or o | 1 Burlel 2 Cremetion 3 4 Donetlon 5 Other (Specify | | | | | |
| Departmental Importal any Injuing | 21. Signature of Funeral Service Licens | 90 1 1 | 22. Name end Add | ress of Fecility Cap | itol Mortuar | y, Inc. |
| 05 # 8 | Karry (| upple | | | | C 20002 |
| | 23s. Part1. Enter the dissatur, or comp shock, or heart failure. List only of | licetions thet caused the deeth one ceuse on each line. | n. Do not enter the mode of dy | ylng, such es cardiec or re | espiretory errest, | Approximete Intervel Between |
| hysician | | 00 1 | (), | 1. 10- | 2 1 | Onset end Deeth |
| Medical xaminer | Immediate Cause (Final disease or condition resulting in death) | · Drady | assythme | a / HS4 | Stole | 20mbs. |
| - T | 1 | Dy6 19 (0 | r es e consequence of): | | 1.50 | 56 |
| and I-transit Xamin | | b. Corono | ary as 1 | eng or | 1) ease | 7294. |
| in and fal-transit Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying | Due to (or | r es e consequence of): | 0 | | Year & |
| | Ceuse (Diseese or Injury thet Initiated events | · reypen | chiff an | | | 178485. |
| g physicil as the bu | resulting in deeth) Lest | W. ac- | 4 | VI | | 1 10000 8 |
| attending for use as | | · myoca | nallo pa | rug | | > yeurs |
| e atte | Pert II. Other eignificant conditions co | ntributing to death but not resu | ulting In the underlying cause of | given p Pert I. | 23b. Did tobacco uea | contribute to the cause of death? |
| ate hes been signed by the attendin , page 2 should be detached for use Completed by Physician/N | Gud ALA | 0 0 0 | 1 1. | 620 | | |
| been signed the should be det | 1000 | 1 - ren | ~ 0 100 | | | 0.45 144 |
| hould | 0 | | | | 24a. Was an autopsy performed? | avelleble prior to |
| hes b | | | | | | of deeth? |
| cate he pege. | | | | | 1□ Yes 2 No | 1 ☐ Yes 2 ☐ No |
| entific Betor | 25. Wes case referred to medical examiner? | Hospital: | | Where | | |
| S D 5 | 1 Yes 2 No | 1 inpatient 2 | PH/Outpetient 3LI DOA | 4 U Nursing Home | | |
| After funer | 1 Neturel 5 ☐ Pending | 28a. Dete of tnjury (Month, Dey Year) | | | . Describe now injury occ | oundu |
| 4 | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of Injury - At he | | | Location (Street and Nu | mber or Rurel Route Number |
| y the | 4 ☐ Homicide determined | building, etc. (Specify | /) | 201 | City or Town, Stete) | |
| Director: d in by the | | | | | | |
| 24 hours after death. Funeral Director: A stely filled in by the fi | 29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | tner: On the basis of exeminet | Gas Station Attendant 18. Mother's Neme (First, Middle, Meiden Sumeme) Jane Patterson 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) Son A315 Lawrence St. Colmar Manor, Md. 20722 State 20b. Piece of Disposition (Mare of certifier), certainty or of the piece) Stewartville Cemetery 1-29-00 20c. Location - City or Town, State Stewartville Cemetery 1-29-00 Laurinburg, N.C 1425 Maryland Ave., NE Wash., DC 20002 Laurinburg, N.C 1425 Maryland Ave., NE Wash., DC 20002 Approximate Interval Between Observal Color of City of Company of Color of City of Color of Color of City of Color of Color of City of Color of | | | |
| othe Funeral Director: After to ompletely filled in by the funeral Medical Certification: | (Check only 2 Medical Exam | relctan: To the best of my know ther: On the basis of exeminet end menner steted. | tion end/or Investigation, In my | opinion, deeth occurred | et the time, date end pled | ca, and due to the cause(s) |
| within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: | (Check only 2 Medical Examone) | tner: On the basis of exeminet | tion end/or Investigation, In my | opinion, death occurred | et the time, date end pled 29d. Date sig | a, and due to the cause(s) |
| within 24 hours after death. To the Funeral Director: After completely filled in by the fune completely filled in Certification. | (Check only 2 Medical Examone) | tner: On the basis of exeminet end menner steted. | ion end/or Investigetion, In my 29c. Licer | r opinion, death occurred the name number | et the time, date end plec 29d. Date sig 1 · 1 7 | ned (Month, Day, Year) |

State Registrar

31. Dete filed (Month, Day, Yeer)

JAN 2 7 2000

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death January 22, 2000 **Physician** Waters, Sr. Walker Lee 8:50 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8 Date of Birth
Month, Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1**X**M 2□ F Yrs. Lee County, GA 79 Director 577-38-8709 March 16, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Llmits ns 23a or 28a-f sh 1 Yes 2 No Directo Adelphi Prince George's Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 20783 United States 1801 Metzerott Road Funeral items : 12. Wes Decedent Ever in U.S. Armed Forces? Rece - American Indian, Bleck, White, etc. 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) "natural", or iten filed within 72 hours after Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Government two years Postman (Mail Carrier) .. Pages 1 and 2 should be filed witness of Health and Mental Hygien tant: If Item 27 Is marked other theirty or other traumatic event, the Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Willie B. Allen Jesse Waters 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11008 Childs St. Silver Spring, MD 20901-4411 Jesse Waters - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any Injury or 1/27/2000 Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service 22. Name and Address of Fecility Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Wash. D.C. 20019 The the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, an eart failure. List only one ceuse on each line. Approximate Intervet Between **Physician** INSU AFTICIANCY /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last burial-trar Due to (or as e consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of): USe es ate hes been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? 1 Yes 2 No certificate 1 Yes 2 No of Vital Physician: 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this the funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred After Division or Attending 1 Naturel 5 Pending investigation Injun 1 ☐ Yes 2 ☐ No death. 2 Accident s after death 6 Could not be determined 3 Suicide in by t 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homleide 24 hours Hospital 112 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and title of zertifier 29c. License number 29d. Date signed (Month, Day, Year) MIXIND NO 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Hanover Pkwy. Greenbelt That Raymon 32. Registrer's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

| | | | | ertificate c | or Death | R | ig. No. | 0 | 4103 |
|--|--|---|---|---|---|---|--|---|---|
| Physician /Medical | Decedent's Nama (First, Middle Billy Gene | | | | | Jan 23, | | Vaar | Tima of Death 4:15 PM |
| Examiner | 4a Facility Nama (If not institution Southern Maryl. | | | | 4b. City, Town, or Clinton | Location of Death | 4c. County Princ | of Death ce Georg | ge's |
| uneral irector | 5. Social Security Number 235 68 9887 | 6. Sex 7. Ag | 9e (In yrs. last birthda 54 Yrs. | y) If Under 1 Ye Months Da | | | | 9. Birthplace Country) Woodman | (Stata or Foraign |
| 1 | Usual Residence of Decedent 10e. State 10b. County | | 10c. City, Town or | Location | | | | | side City Limits |
| er sho | MD P.G | | | r Marlbo | ro | | 1 □ Yas XVN | | |
| 23a or 2 at be no | 10e. Street and Number 8903 Pensacola | a Place | | 10f. Zip Cod | 0772 | | og. Citizen of V United | | |
| Important: if Nem 27 is marked other than "natural", or them 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Marri 3 Widowed Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | B. Was Decedent of If Yes, specify C | of Hispanic Origin? (Suban, Mexican, Pue No Specify: | Specify Yas or No- to Rican, etc.) | | e - American Inck, White, etc. | |
| d other than "nature event, the leader!" Be Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | | (Gir | cedent's Usual Oc ve kind of work do . DO NOT use re K Mason | cupation ne during most of wo lired) | orking | 16b. Kind of Bu | usinass/Industry | |
| To Be Co | 17. Father's Name (First, Middle, I Claude Wolford | | | | 18. Mother's Na | me (First, Middle, M | | | |
| ther treum | 19a. Informant's Name/Relationst Sandy Wolford 20a. Mathod of Disposition | | 778 | | eet and Number or R | ural Route Number kandria , | Va 223 | | |
| cian lical iner | 21. Signature of Furtiral Service I 23a. Part? Enter the disease, or shock, or heart failura. List of the disease or condition resulting in death) | 11/2 | d the death. Do not one. | 22. Nama and Ad Alexandr wher the mode of | | e Funeral Road, Cli | Home, I | laryland Applintal Ons | 3 01d |
| for use as the buriel-transit clan/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. BRAIN | Due to (or as a cons Due to (or as a cons | equence of): | 15. | | | | 5/1999 |
| | | d | | | | | | 1 | |
| 75 25 | Part II. Other significant condition | s contributing to death be | ut not resulting in the | underlying causa | given in Part I. | 23b. Did 10 | bacco usa cor | ntributs 10 the | causs of death? |
| be detect by Phy | Part II. Other significant condition | s contributing to death be | ut not resulting in the | underlying causa | given in Part I. | 23b. Did 10 | | | causs of death? |
| hes been signed by the 2 should be detect mpleted by Phy | Part II. Other significant condition | se contributing to death bi | ut not resulting in the | underlying causa | given in Part I. | 1 | n autopsy | 3 Probably 24b. Wara a | 4 Unknown |
| ertificate has been sign ector, page 2 should be Be Completed by | 25. Was casa refarred to medical examiner? | | ut not resulting in the | | 26. Piace of De | 1)2(Y | n autopsy ned? | 3 Probably 24b. Wara a availabl complet | 4 Unknown |
| After this certification funeral director funeral director funeral director funeral director funeral f | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | Hospital: 1 tnpatie 28a. Data of Inju (Month, Da) | ont 2 ER/Outpell | ient 3 DOA | 26. Piace of De | 24a. Was a perform | n autopsy ned? | 3 Probably 24b. Wara a available complet of death 1 Yast ar (Specify) | 4 Unknown |
| After this certification funeral director floor: To Be | 25. Was casa refarred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | Hospital: 1 Inpatie 28a. Data of Inju (Month, Da) | ent 2 ER/Outpat ry Year) 28b. Time Injury ury - Al homa, farm, | Sent 3 DOA of 28c. t | 26. Place of De Other: 4 Nursing | 24a. Was a perform | n autopsy ned? as 2) No e) once 6 Othow injury occurs | 3 Probably 24b. Wara a available complet of death 1 Yester (Specify) ar (Specify) | 4 ☐ Unknown utopsy findings e prior to ition of cause ? S 2 ☐ No |
| lor: After this certifithe funeral director cation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastig 2 Accident 3 Suicide 6 Could n detarmi | Hospital: 1 Inpatie 28a. Data of Inju (Month, Da) ation bibe 28e. Place of Inju | ont 2 ER/Outpati ry Year) 28b. Time Injury ury - Al homa, farm, c. (Specify) of my knowledge, de- | ient 3 DOA of 28c. to 28c. to 3 DOA street, factory, offi | 26. Place of De Other: 4 Nursing njury st Nork? 1 Yas 2 No ce | 24a. Was a perform 1 Ye wath (Check only on Homa 5 Raside 28d. Describe how 28f. Location (St. City or Town | n autopsy ned? as 20 No e) ence 6 Othow injury occurring the properties of the prop | 3 Probably 24b. Wara a available complete of death 1 Yes ar (Specify) red | utopsy findings e prior to iton of cause 17 A S 2 No |

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State

Registrar

31. Data filed (Month, Day, Year) JAN 2 7 2000

G. Sparke

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State of Maryland / Department of Health and Mental Hygiene 00 04 170

| | | | | | Ce | rtitica | te or | Death | | | Reg. No. | | | |
|--|--|---------------------|-------------------------------------|--------------------------|--|------------------|-------------------|------------------------|-----------------|---|-----------------------------------|-----------------------------|--------------------------|-----------|
| Physician | 1. Decedent's Name (First, Min | | | | | | | | | 2. Date of De Month | Day | Year | 3. Time of 0 | |
| /Medical | Daibala Lee | | | | | | | 41 Oh . T- | | Januar | - | | 6:55 | a.m. |
| Examiner | 4a Facility Name (If not institution 5007 Ravenswo | | | nber) | | | | Rive | | e | | | orge's | 3 |
| Funeral Director | 5. Social Security Number 299-30-9444 | 6. Sex | M 2⊠F | 7. Age (In yrs. | last birthday) Yrs. | tf Und Months | or 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, De March 2 | th by, Year) | 9. Birthpli Count Ohi | ace (State or | Foreign |
| Director | Usual Residence of Decedent | | | 0.5 | | | | | | march 2 | ., 1930 | OIII | 5 | |
| with the Maryland a or 28a-f show be notified at Director | N -1 1 D 1 | | | | | | | | | | | 10 | 0d. Inside City | |
| or 28a-f s be notified | 10e. Street and Number | | | | | 10f. Z | ip Code | | 100 | 10g. Citizen of What Country? | | | | |
| 23a o unit ba | | od Ro | ad | | | | 207 | 37 | | | U.S.A | | | |
| r here 23a sizer must b | 11. Marital Status | 12 | 2. Was Dece Armed For | dent Ever in t | J,S. 13. | Was Dec | edent of H | lispanic Ori | gin? (Sp | ecify Yes or No Rican, etc.) | | e - America | | T 1. |
| ors at | 3 ☐ Widowed 4 ☐ Divord | | 1 Tes If Yes, Give Year or Da | 2 X No | | 1□ Yes | | | | | Specif | | | |
| natural, dical Exp | 15. Deced | ent's Educe | etion completed) | | 16a. Dece | dent's Us | ual Occup | ation during mos | t of work | ina | 16b. Kind of B | usiness/Ind | ustry | |
| ad within 72 ho rigians. wr than "naturn t, the Medical is Completed | Elementary/Secondary (0-12 | | College (1- | -4or 5+) | | | | during mos | | | 0.1 | / | | |
| | | lo Loct) | | | Data | Proc | essi | ng Cl | | o /First Middle | Singer Maiden Sumen | | Corpor | ratio |
| BES ES | | | | | | | | | | | | 10) | | |
| d Men merks metic | 19a. Informant's Name/Relation | | | | 10h Maii | a a Addro | ne (Street | | | nn Sher | er, City or Town, | State 7in | Codel | |
| d 2 sh th and 7 is m | Albert E. Wes | | | 1 | | | | | | | le, MD | | 0000/ | |
| Health Hem 27 other tr | 20a. Method of Disposition | | | 20b. | Place of Dispo | osition (N | eme of | | | Date | 20c. Location | | wn, State | |
| artment of octant: If the injury or o | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, cremetory or other Metropolitan Cr | | | | | | | | 1 | 1/26/00 | Alexan | dria, | Virgi | lnia |
| Depart Import any in | 21. Signature of Funeral Servi | Ce Licensee | A | 1 2 | | | | ss of Facilit neral | | ne | | | | |
| 201000 | Clau | del | lec | V. 2 Da | ach 4 | 739 I | Balti | more | Aven | ue, Hya | attsvill | e, MD | 20781 | |
| | 23a, Part1. Enter the disease shock, or heart feilure. L | ist only one | cause on ea | ach line. | tri. Do not en | TOL THE THE | ous or dyn | ig, such as | Cerdiac | or respiratory a | irrest, | | Interval Betwo | Neen |
| Physician /Medical | Immediate Cause (Final | | | | | | , | | | | | | | |
| Examiner | disease or condition resulting in death) | a. | CA | RCIA | or as a conse | 4 | 64 | BVI | 111 | | | | 3 yn | |
| à | | | | Due to (| or as a conse | quence of |): | | | | | 1 | | |
| axecuted in and ial-transit | | b . | | 5 | | | | | - | | | 1 | | |
| certificate be axecuted ding physician and use as the burial-transit VMedical Examin | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury | | Due to (or as a consequence of): | | | | | | | | | | | |
| siclar buri | | c | | Due to 6 | | | | | | | | 1 | | |
| incate be associated to physician and as the burial-transit | resulting in death) Last | | | Dua to (| or as a consec | quance of |): | | | | | t | | |
| use use | | d. | | | | | | | | | | | | |
| e attan ed for u | Part II. Other significant cond | itions contr | ibuting to de | ath but not re | sulting in the u | ınderivina | cause di | en in Pert i | l. | 23b. Did | tobacco use co | ntribute to | the cause o | of death? |
| ach ach | | | | | | | | | | | Yes 21 No | | oebly 4 🗆 t | |
| 5 0 0 | | | - | | | | | | _ | | | | | |
| been sign should be | | | | | | | | | | 24a. Was | an autopsy ormed? | ava | ere autopsy fi | 0 |
| 2 2 5 | | | | | | | | | | | | | mpletion of ca death? | ause |
| The tage page | | | | | | | | | | 10 | Yes 2K No | 1 [| Yes 20 | No |
| ysician: The sectificate director, page Co | | cel | | | | | | 26. Place | of Deal | th (Check only | one) | | | |
| 7 00 | 1 Yes 2 No | Ho | spital: 1 🗆 fr | petiant 2 | ER/Outpetie | nt 3 🗆 [| ON ON | her: 4□ Nu | ursing Ho | ome 5 Res | idance 8 Dott | ner (Specify |) | |
| After thi funeral flon: 1 | | dina | 28a. Date o | f Injury h, Dey Year) | 28b. Time o | of | 28c. tnju Wo | ry at rk? | | 28d. Dascribe | how injury occur | rred | 145 | |
| Attending or death. •ctor: After by the fune iffication | 2 Accident inva | stigation | | 1100 | | М | | Yes 2 | No | | | | | |
| tal or Attending P rs after death. al Director: After led in by the funer Certification: | 3 Suicide 6 Cou 4 Homlcide dete | ld not be emined | | of Injury - At h | nome, farm, st | reet, facto | ry, office | | | | (Street and Num. wn, State) | ber or Rure | l Route Numb | ber, |
| To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical Certificati | | | | sis of axamin | | | | | | | cause(s) and m date and place, | | |) |
| ithin ithe omple | 29b. Signature and title of cert | fier | ano mem | or stated. | | 2 | 9c. Licens | se number | | | 29d. Data signe | d (Month, I | Day, Year) | |
| - 3 - 8 | D | 4 | 1/ | 14 | | | | 589 | 9/ | | January | | | |
| (10) | K O gu | B. + | 764 | nu (s/) | - 00 1 = | D-I-1 | 0 | - 0 1 | - | | Janual | 20, | 2000 | |
| (13) | 30. Name and address of pers Roger B. Ingha | | | | | | 0 11 | 2/100 | D-1 | ordele | MD 207: | 2.7 | | |
| | 31. Data filed (Month, Day, Ye | | | egistrar's Sign | CARLES TO SECURITION OF THE PARTY OF THE PAR | II AV | C. 1/ a | 400, | VIA | eruare, | FID 207. |) / | | |
| State | 10N 2 7 7 | กกก | 1 | rytotrat o OIGN | 4 | 1 | | , | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JANUARY 23, 2000 2:31am JOHN J. WADDY /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F Months 63 Yrs. MAY 5, 1936 Director VIRGINIA 154-26-9858 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show i the Maryta Yes 2 No MD. MONTGOMERY Director STLVER SPRING 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 munt be 8514 11th AVENUE 20903 Roma 23a United States of AMERICA Funeral 12. Was Decedent Ever in U,S. Amned Forces? 12 AYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black White etc. affer 1 Never Married Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: Black À 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th grade MAIL CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Manial. Important: If Item 27 is merically injury or d 2 should be fi th and Mental F 7 is marked off Be 10 HERBERT L. WADDY

19a. Informant's Name/Relationship (Type, Print) MARTHA SPICER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA J. WADDY / WIFE 8514 11th AVE. SILVER SPRING MARYLAND 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/00 GLENWOOD CEMETERY WASHINGTON, D.C. 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 KENNEDY ST NW WDC 20011 WIL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical arcinone Examiner Examiner physician and the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 0 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. P.O. the signed by t 1⊠ Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed **5 958d** has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No veral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and married stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certi 1-24-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie MD 20710

State Registrar

DHMH 16 Rev 6/95

AN 32. Registrar's Signature

JAN 27 2000 Some & works

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Menta

| al Hygiene | 00 | 04 | 17 |
|------------|----|----|----|
| Don Ma | | | |

29d. Dete signed (Month, Dey, Year)

January 19, 2000

| Luther | P. | Wi | lson |
|--------|----|----|------|

| Luther P. | . 1 | Wilson | | | Cer | tificate | of i | Death | | Reg. No. | 0 0 | 7116. |
|---|-----|--|--|-----------------|--|---------------------------------|---------------|--|--------------------------------------|-------------------------|--------------|--|
| L | | 1. Decedent's Neme (First, Middle, La | st) | | | | | | 2. Dete of D | | Van | 3. Time of Deeth |
| Physician /Medical | | LUTHER PERNE | LL WILS | ON | | | | | Janua Janua | ary 18, | 2000 | 13:13 |
| Examiner | _ | ta Facility Neme (If not Institution, given | re street and number, |) | | | | 4b. City, Town, or | | | fy of Death | |
| | | Prince George's | Hospital | | | | | Cheverly | 7 | Prin | ice Ge | orge's |
| Funeral | . 5 | 5. Social Security Number 6. S | Sex 7. A | ge (In yrs. las | st birthdey) | If Under 1 Y | Yeer | If Under 24 Hrs | 8. Dete of B | | | plece (State or Foreign |
| Director | | 578-74-8631 | M 2□F | 45 | Yrs. | Months D | leys | nouis Min | Septemb | er 24,195 | 4 Washi | ngtan, D.C. |
| 7 . | - | Usuel Residance of Decedent | | T | | | | | | | | |
| show the | | 10a, Stete 10b. County | | | Town or Lo | | | | | | | 10d. Inside City Limits |
| or 28s-fa be notified | 000 | Maryland Prince Ge | orge's | Hyat | tsvill | .e | | | | | | 1 X Yes 2 □ No |
| or 2 | 5 | 10e. Street end Number | | | | 10f. Zip Co | | 505 | | 10g. Citizen of | | ntry? |
| 4 62 m | | 1502 Sherwood Co | ourt | | | | | 785 | S-15. | U.S | | |
| Interchasts with the Marylar rates 23e or 28e-f show siner must be notified at Prunaral Director | BUT | 11. Meritel Stetus | 12. Wes Decedent Armed Forces | Ever in U,S. | 13. V | Vas Decedent Yes, specify | t of H | lispenic Origin? (S an, Mexicen, Puer | Specify Yes or N to Rican, etc.) | lo- 14. Re | eck, White, | |
| | | 1 Never Merried 20 Merried | 1 Yes 2 If Yes, Give | No | | ☐ Yea 20 | _ | Specify: | | Speci | | lack |
| 5-002 72 hours a natural, o Scal Exam | | 3 Widowed 4 Divorced | Year or Detes: | | | | | | | | | |
| 21215-0 ed within 72 ho ygjene. we than 'naturn 4, the Medical. | 910 | 15. Decedent's E (Specify only highest gra | ducation ade completed) | | 16a. Deced (Give | ent's Usuel O kind of work o | опе | etion during most of wo d) | rking | 16b. Kind of I | Businass/In | dustry |
| 121 | E I | Elamantery/Secondary (0-12) | | | | | | | | D | | |
| T Page 2 | | 12th 17. Father'a Neme (First, Middle, Last | | | Maintenance Worker | | | | rivat | 6 | | |
| Be sver | ā | Pernell Stokes | , | | 18. Mother's Nama (First, Middle, Malden Amelia Wilson | | | | | | uen Surname) | |
| Maryland 21215-0020 6 2 should be fised within 72 hours at th and Merial Hygiene. "natural", or traumetic event, the Medical Exam To Be Completed by 8 | | 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end | | | | | | | | | | |
| Mar 12 sh 14 mar 14 mar | | Vanessa E. Wilsor | * . | | | | | | | | | nd 20785 |
| CINE | - | | 1) MILE | OOb Bio | | sition (Neme | | Court, | • | _ | | |
| 0 10 10 10 10 10 10 10 10 10 10 10 10 10 | 1 | 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ | Removel from State | 000 | netery, cren | netary or othe | r pled | (9) | 01 /25 | 20c. Location | | |
| tim bant bant | | 4 □ Donetion 5 □ Other (Special | | Res | | ction (| | | 2000 | Clinto | n, Ma | ryland |
| Baltimore, semil. Pages 1 a appartment of Ham reconstruct if Nem reconstruct if Nem reconstruction | | 21. Signeture of Funerei Service Lice | nsee | 1. | J. | B. JEN | Addre VK I | SS of Fecility | RAL HOME | 2 | | |
| m 20238 | | Nancus A | · Percen | the | | | | ver Road | | | rylan | d 20785 |
| - | | 23a. Pert1. Enter the disease, or comshock, or heert failure. List only | plicetions thet cause one cause on each I | d the deeth. | Do not ente | er the mode o | f dyin | ng, such es cerdie | c or respiratory | errest, | | Approximete tntervel Between |
| Physician | | | | | | | | | | | 1 | Onset end Deeth |
| /Medical | | Immediate Cause (Finei disease or condition | Gur | shot | W/0 | und | of | Abd | omen | | | |
| Examiner | | rasulting in deeth) | e | Due to (or e | | | 0 1 | | | | | |
| P = 5 | | Mary III and | | | | | | | | | | |
| OX 68760, certificate be executed ring physician and use as the burial-transit | | Sequantially list conditions, | D | Dua to (or a | s e conseq | uence of): | | | | | | |
| Ex Liai- | | Sequentialty list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): | | | | | | | | | i | |
| 68760, ifficate be exergent by physician a as the burial-ledical Ex | 2 | that initiated events resulting in deeth) Last | C. Due to (or es a consequence of): | | | | | | | | | |
| ndiffica ng pl | | | | | | | | | | | | |
| Box 6 eath certific attending p for use as | | | d | | | | | | | | 1 | |
| P.O. BO) et the death ce d by the attend etached for us. | 100 | Pert II. Other significant conditions of | contributing to death b | out not resulti | ing in the ur | nderlying ceus | se giv | ren in Pert I. | 23b. Die | d tobacco uas c | ontributa t | o the cause of death |
| P.O. at the de disched etsched | | | | | | | | | 10 | Yes 20 No | 3 Pro | bably 4 Unknow |
| S & & & > | | | | | | | | | | | | |
| Records, P he law requires that e hes been signed b age 2 should be det | | | | | | | | | | s an autopsy formed? | 24b. W | fara autopsy findings veileble prior to |
| law re | 2 | | | | | | _ | | | | of | ompletion of cause deeth? |
| The taw requir | 5 | | | | | | | | 1/5 | ¥ea 2□No | .1 | ZYes 2□ No |
| Of Vital Physician: T this certificat ral director, pr | D 2 | 25. Wes case referred to medical | | | | - | - | 26 Place of De | eth (Check only | | | |
| Of Vita Physician: this certific ral director, | | exeminer? XMEX/es 2□ No | Hospital: | ient XXX | 3/Outnetien | 3 DOA | Oth | ar | | sidance 6 🗆 O | thar (Sneci | 6/) |
| Phy Prthis eral eral | - | 27. Menner of Death | 28e. Deta of Inju | ury 2 | 8b. Time of | | Injur Wor | | 1 | e how injury occi | | |
| nding oth. : After e fune | 2 | 1 ☐ Neturet 5 ☐ Pending investigatio | 1-18-00 | | Injury | М | 1 🗆 | Yes 2 No | subjec | t shot | | |
| Division or Attending after death. Director: After d in by the fune ertification | | 3 ☐ Suicide 6 ☐ Could not b | e 28e. Plece of th | jury - At hom | | | | | 28f. Location | (Street end Nun | nber or Rur | al Route Number. |
| Division (bit or Attending P as after deeth. If Director: After ted in by the funera Certification: | | 4 21Homicide | building, a | (C. (Specify) | 5h | opt | | | Lando | WAL ME | 4 Capir | 61 New Dr |
| oapital hours a uneral c ily lilled | | 29a. Cartifier 1☐ Certifying Ph | ysician: To the best | of my knowle | | | the tir | ne, date end plec | | | nannar as s | stated. |
| 0 - 3 - () | 20 | (Check only - A Fried and and Fried | alman On the healt - | A numering at - | a and/asi- | andination !- | - | whater don't con- | consist of the state of the state of | | and divine | a the agreement of |

31. Dete filed (Month, Day, Year)

JAN 2 4 2000

huten 32. Registrer's Signeture

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

DHMH 16 Ray 6/95

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

James & speed

3442 4 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** William Theodore Walker January 15 2000 9:35AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 1902 Brewton St. District Heights Prince George's 5. Social Security Number If Undar 1 Yaar] If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours Min 10M 20F 577-58-9384 Yrs. 52 **Director** Jan. 26, 1947 Wash., D.C. Usual Rasidance of Dacedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar maint be notified at 1 Yas 2 □ No Directo Prince George's Maryland District Heights 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 1902 Brewton St. 20747 United States Funeral death 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☑XYas 2 □ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Biack, White ican should be filed within 72 hours after 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: American by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry s and Mental Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th General Mechanic Government 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumema) Nannie Mae Francis William Scott 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m Theresa Walker - Wife 1902 Brewton St., District Heights, MD 20747 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 6 4 ☐ Donation 5 ☐ Othar (Specify) any injury Ft. Lincoln Cemetery 1/22/2000 Brentwood, MD 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart fallure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 1 mo PNEUMONIA Examiner Due to (or es e consequence of): Examiner ACUTE MYELOGENOUS LEUKEMIA 14 MO hysician and the burial-transit certificata be axecuted Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Lest Box 68760, Physician/Medical Dua to (or as a consequence of) use as ! for 23h. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Probably 4 Unknown Division of Vital Records, þ 8 24a. Wes an autopsy performed? 24b. Ware eutopsy findings available prior to Completed complation of ceusa of death? has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificata 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Presidence 6 Other (Specify) P 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28a, Deta of Injury (Month, Day Year) 28b. Tima of After Certification: Attending 1 Natural 5 Pending aftar death. 1 Yas 2 No Invastigation 2 Accident 6 ☐ Could not ba datarminad 28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stela) 3 4 I Homicida 8 Hospital 24 hours 29a, Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. edical (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, dete end place, and due to the causa(s) and mannar stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. Licansa number DC 11241 raldius 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) GERALDINE P. SCHECHTER MD. VAMC 50 IRVING ST-NW WASHINGTON DC

State Registrar 31. Data tilad (Month, Day, Year)

JAN 2 4 2000

32. Registrar's Signatura

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

| ician dical | Decedeni's Name (First, Middle, Last, TIMOTHY QUI |) | nd Department o Certificate | | 2. Date of Dea Month JANUARY | th Day | Year 0845 AM | | |
|----------------|--|--|---|--|------------------------------------|---|---|--|--|
| r | 4a Facility Name (If not institution, give 1805 BELLE HAVEN | street and number) DRIVE # 203 | | 4b. City, Town, or Lo LANDOVER | cation of Death | | of Death E GEORGES | | |
| | 5. Social Security Number 6. Security Number 18 | x 7. Age (In yrs. 36 | last birthday) If Under 1 Ye Months Da | | 8. Date of Birth | (Sear) | 9. Birthplace (State or Fore Country) WASHINGTON, | | |
| | Usuel Residence of Decedent 10a. State MARYLAND PRINCE G | | ty, Town or Location LANDOVER | | | | 10d. Inside City Lim X ⊠ Yes 2 □ f | | |
| - | 10e. Street and Number 1805 BELLE HAVE | EN DRIVE #203 | 10f. Zip Cod 2 (| 785 | | 10g. Citizen of What Country? UNITED STATES | | | |
| - | 11. Maritel Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: | J.S. 13. Was Decedent If Yes, specify C | of Hispanic Origin? (Spouden, Mexican, Puerto No Specify: | ecify Yes or No- Rican, etc.) | | 14. Rece - American Indian, Black, White, etc. Specify: AFRO-AMERICAN | | |
| | 15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12) | cetion e completed) College (1-4or 5+) | 16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re STOCK CLI | ing PRIVATE | | | | | |
| 1 | 7. Father's Name (First, Middle, Last) JOSEPH M | MELVIN JONES | | 18. Mother's Name MARY EL | | | | | |
| | 19a. Informant's Name/Reletionship (Ty Mary E. DeMar/MC | | | ral Route Number, City or Town, State, Zip Coda) 203, LANDOVER, MD 20785 | | | | | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location | | | | | | | | |
| edical Examine | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last | b | or as a consequence of): or as a consequence of): or as a consequence of): | | | | | | |
| | | ntributing to death but not res | sulting in the underlying cause | given in Part I. | | obacco use co | ntribute to the cause of dea | | |
| | Part II. Other significant conditions cor FATTY LIVER | | | | | | T | | |
| | | | 196, 4 | | | an autopsy med? | 24b. Were autopsy finding available prior to completion of cause of death? | | |
| | FATTY LIVER | | | 28. Place of Deat | perfor | med? | available prior to completion of cause | | |
| | FATTY LIVER 25. Was case referred to medical examiner? ↑ TXX'es 2□ No | Hospitel: 1 ☐ Inpatient 2 ☐ | | 28. Place of Deat | h (Check only o | med? es 2□No ne) | available prior to completion of cause of death? 1 Yes 2 No | | |
| | FATTY LIVER 25. Was case referred to medical examiner? 12. Wasner of Death 1. Netural 5 Pending investigation 3 Suicide 6 Could not be | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No | h (Check only o | rmed? es 2 No ne) lence 6 Oth now injury occur Street and Numb | available prior to completion of cause of death? 1 Yes 2 No | | |
| | FATTY LIVER 25. Was case referred to medical examiner? 12 Xes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined 29e. Cartifier 1 Certifying Physical Could Polyton Physical Certifying Physical Cartifying Physical Certifying Physical Certif | 28a. Date of Injury (Month, Day Year) 28e. Piece of Injury - At he building, etc. (Special Control of the Cont | 28b. Time of 28c. 1 | Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No ice | h (Check only o | res 2 No re) lence 6 Oth row injury occur Street and Number, State) | available prior to completion of cause of death? 1 Yes 2 No No rer (Specify) Tred ber or Rural Route Number, | | |

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Sep. 2 2880 Same

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Hom# 24a Per Physician 1-31-2000 ccHD FCB Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Jan. 27, 2000 **Physician** 10:53AM MARY ELLEN WILLIS : /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) **Funeral** 10M XOF Months Deys Yrs. 76 033-12-2558 **Director** Usual Rasidance of Decedant 10c. City. Town or Location 10d. Insida City Limits 10a Stata 10b. County Items 23s or 28s-f show ther must be notified at 1 Yas 2 No Charles Newburg Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 12398 Channelview Drive 20664 USA 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Detas: 13. Wes Decedant of Hispentc Orlgin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married 6 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced "natural" 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Educetton (Specify only highast grade completed) Elamantary/Secondery (0-12) Cotlega (1-4or 5+) Jewelry Industry Secretary 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) 12 should be fi and Mantel H Is marked of Thomas J. Porter Mae Surgeon Porter 2 19b. Malling Addrass (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Dependent Pages 1 and 2
Dependent of Heelth an Important: If Itam 27 is many holury or other any holury or other. Carolyn Bauer/Personel Rep. 48 Bralan Crt. Gaithersburg, MD 20877 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory1/28/00 Alexandria,VA 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licensaa AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Entar tha disaasa, or complications that coused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest. MD 20646

Approximate Interval Between Onset end Deeth **Physician** Immediate Ceusa (Finet disaasa or condition rasulting in daath) Metmobil /Medical Examiner Examiner Dua to (or as a consequence of): physician and the burial-tran Sequantially tist conditions, if any, taading to immadiata ceusa. Entar Undarlying Causa (Disaase or injury the death certificate be execu Physician/Medical that initiated avants resulting in deeth) Lest Due to (or es e consequence of): 980 Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? obs twelve 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ð pulmony Discore 24b. Wara autopsy findings evailabla prior to complation of cause of death? 24e. Wes an autopsy performed? Completed certificata has 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medical axaminar? Be 26. Place of Deeth (Check only ona) Othar: 4 Nursing Home 5 Residance 6 Other (Specify) 1□ Yas 2No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: of or Attending Patter of the Court of the C 1 Naturat Accident 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 3 Suicida 28a. Place of tnjury - At homa, ferm, straat, fectory, office building, atc. (Specify) 4 Homlcida To the Hospital within 24 hours a To the Funeral C edical 29a. Certifier Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data end place, and dua to tha ceusa(s) and mannar as stated.

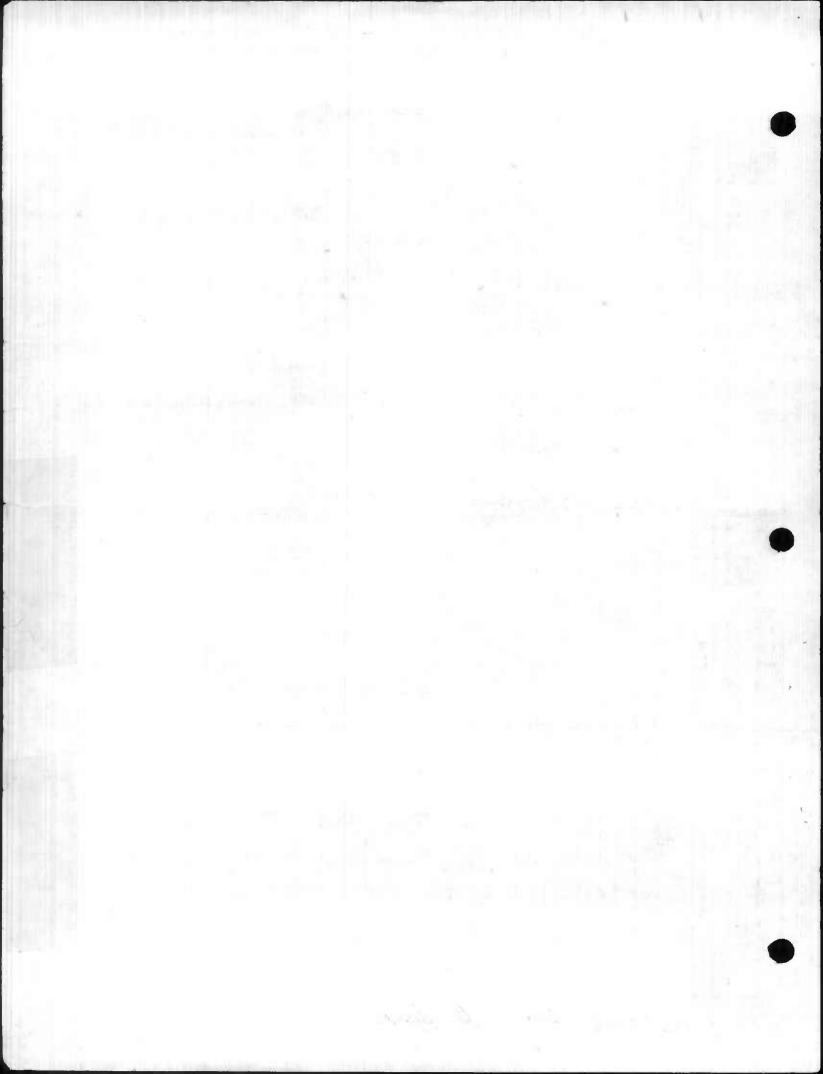
Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, dete and place, end due to the cause(s) and mannar stated. (Check only 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 36206 Kiran mehta, MD 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) Holly Wood medical 31. Data filed (Month, Dey, Year) JAN 3 32. Regimen's Signetura State Registrar

DHMH 16 Ray 6/95

And the control of th

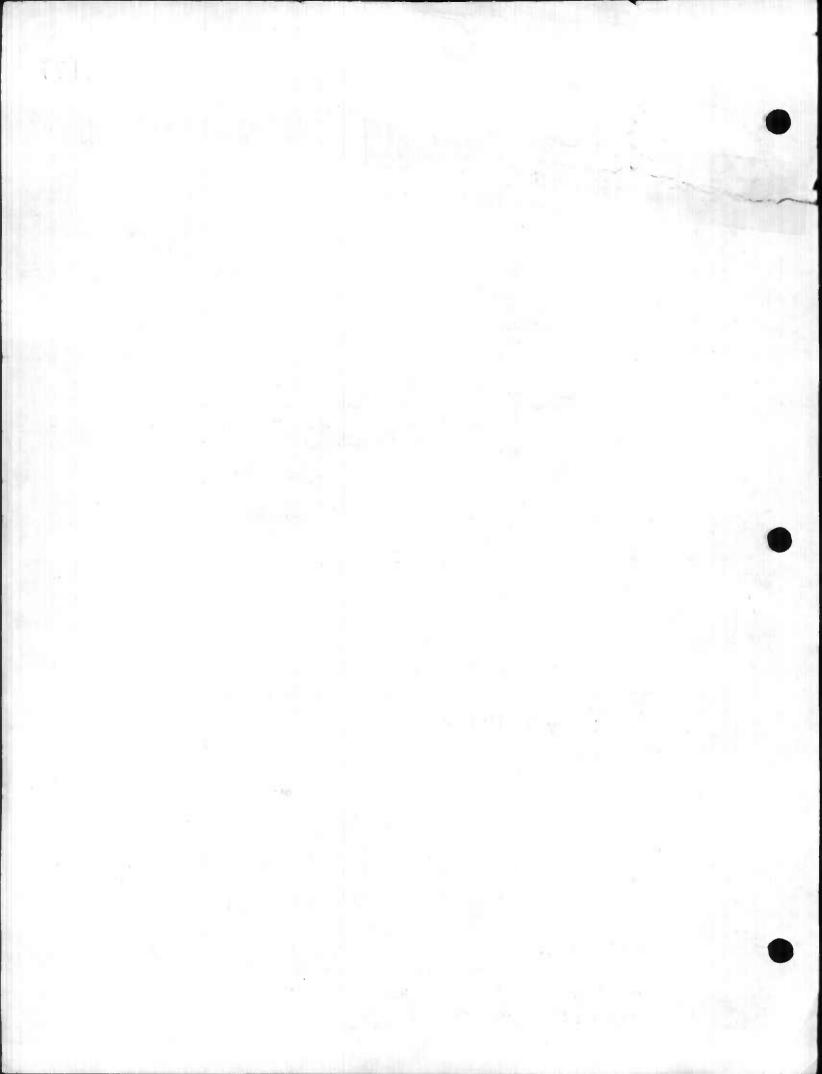
Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death Day Yaar Month **Physician** Nina Delores Wiedenhoeft 2000 3:29 a.m /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Nursing & Rehabilitation Ctr. Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) Baltimore **Funeral** Months 216-12-3246 1 ☐ M 2 F 93 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Baltimore 1 Yes 2 No Directo 288-1 10e. Street and Number 2725 Kildaire Drive 10f. Zip Code 10g. Citizen of What Country? ò 21234-7634 U. S. A. Norma 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian. Black, White, etc. hours after ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker 12th 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of Charles Strott Charlotte Minnie Ramsey Strott 2 19a. Informant's Name/Relationship *(Type, Print)* Janis Walker-Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Morgan Street, Berkeley Springs, WV 2541 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, State tery, cremetory or other place) 2-8 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Smithsburg Crematory 2000 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunter-Anderson Funeral Home 21. Signature of Funeral Service Licenses \$. Mercer Street, Berkeley Springs, WV 2541 23a fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Physician YOLARDIAE INFARCTION /Medical Immediate Cause (Final CUTE disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be execu Box 68760, Physician/Medical the Dua to (or as a consequence of): 88 980 signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown EMENTIA Records, þ The law requires Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 PNO 212 No certificate of Vitai or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Aftar Division 5 Pending investigation 1 Netural ie Hoapital or Attending n 24 hours after death. se Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manger stated. within 2 To the the the 29b. Signature and title of cartifiar 29c. License number 29d. Date signed (Month, Dey, Year) 2000 suell 30 Name and address of person who completed cause of deeth (Item 23a) (Type, Print)/ ~ AKITANI, 7220 SNEEM 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95

ORIGINAL



State Registrar

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#1,12,16a&b,17&18 per phy G807 5Centificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Year **Physician** FEBRUARY 5, 2000 CHARLES E. ALLEN 10 A.M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 44. County of Death Examiner 902 WHEELER AVE. BAUTO. If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days 1₩ 2□F 90 Yrs. 217-05-2302 Director VA Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director MD. N/A BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norma 23a Funeral USA 902 WHEELER AVE 21216 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☐ No # Yes, Giva Yaar or Datas: 1—20—43 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) POSTAL LIDEK 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be fisid within Department of Health and Mental Hygiene. Important: If them 27 is marked other then " any Injury or other trauments event. The Mac PASTORAL WORKER

PASTORAL WORKER GOVERNMENT Elementary/Secondary (0-12) Collega (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZA FAUNTLEROY 2 CHARLES J. ALLEN ELLIZA FAUNTLEROY CHARLES ALLEN 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 KYLE CT. BALTIMORE, MARYLAND 21244 VAILE LEONARD (NIECE) 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 Donation Dothar (Specify) ARBUTUS MEMORIAL PARK 2-10-2000 BALTIMORE, MARYLAND eral Service Licensa 22. Nama and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a Fart. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrest, ack, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical eavy Examiner Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed ician and burial-trans Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably A Unknown Records, by Completed 24b. Were autopsy findings available prior to 24e. Wes an autopsy completion of cause of death? The law director, page 2 1 Yas 2€No 1 ☐ Yas 2 ☐ No Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wes casa rafarred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA jo 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Division 1 SNetural 5 Pending Invastigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 28a. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide • Funeral 29e. Certifier 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Fune completely fi 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) D37573 0005,8 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 16 Rev 6/95

State

Registrar

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7220 Park

32. Registrar's Signature

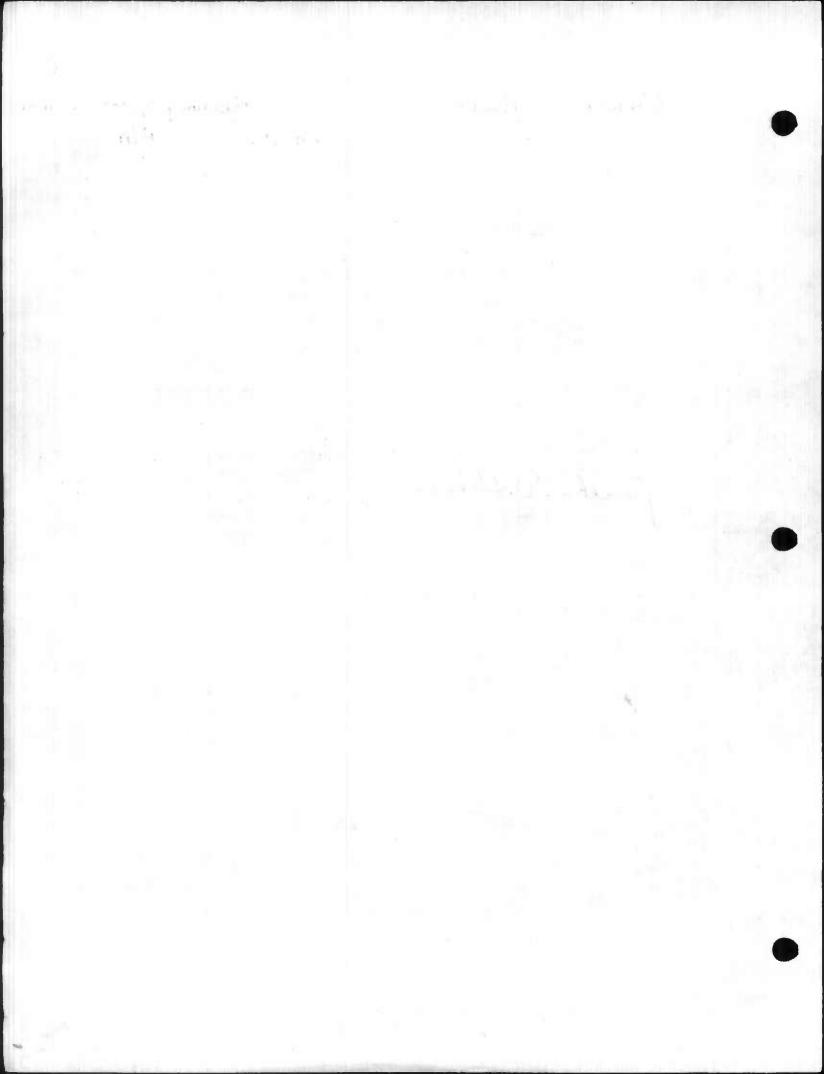
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31. Data filed (Month, Day, Year)

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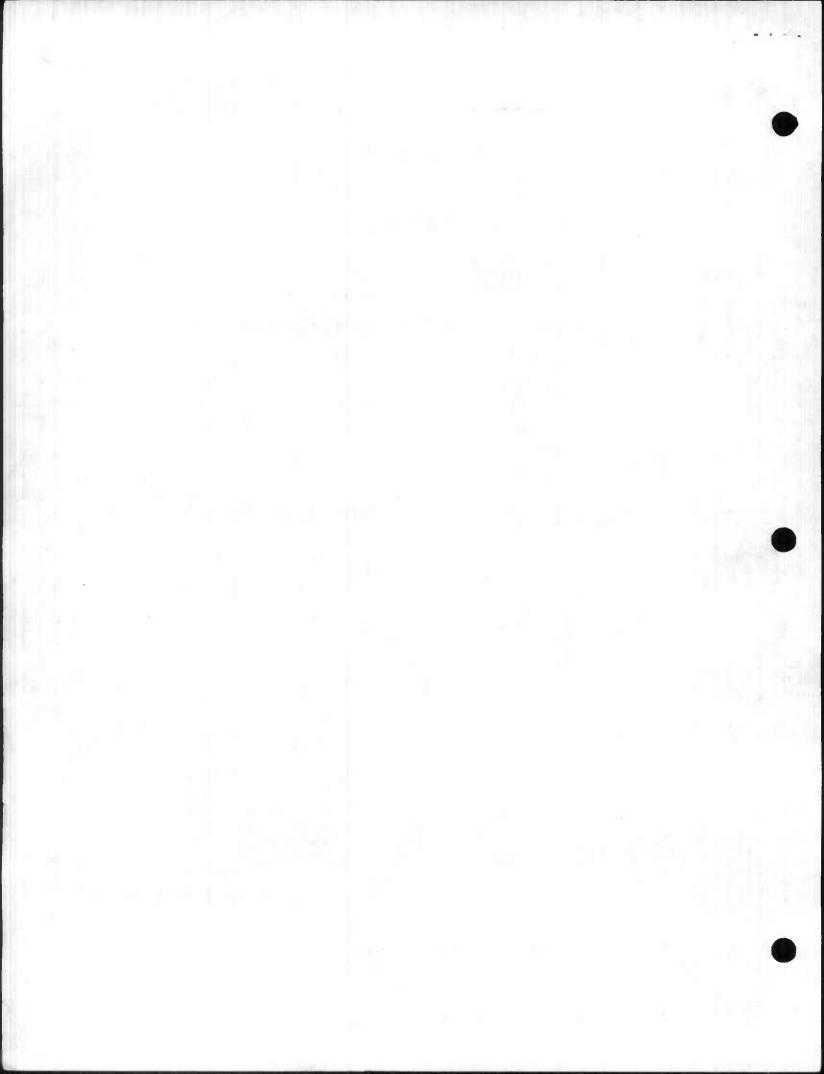
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \bigcap amend item 1 per md G782 4/27/00 yg Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 20.00 Physician JAN 3154 Geneva F Angel 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Memoria 7. Age (In yrs. last birthday) MION H Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 238-20-2330 1 M 2 X F NORTH Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 10g. Citizen of What Country? 10a Street and Number 10f. Zip Code 8 12. Was Decedent Ever in U.S. Armed Forces? 2/220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specity: White 21215-0020 b Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10Me unknown Baltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental onne 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19q. Informant's Name/Ralationship (Type, Print) or other tra 21220 OSEMORI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 5 1 Burial 2 Cremation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 2000 21. Signature of Funeral Service Licensee Evans 22. Name and Address of Facility Funeral 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical DRONARU Month Examiner Due to (or as a consequence of): Physician/Medical Examiner PTI FRAL uleks The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Jang rene Box 68760. the Due to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 200 No 1 ☐ Yas 200 No 1 Yes or Attending Physician: 25. Was case referred to medical axaminer? edical Certification: To Be 26. Place of Death (Check only one) Hospital: Inpatient 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death
1 R Natural
2 Accident 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 24 hours after death. Funeral Director: A 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar AT-2438946-P23 FMUBBA, M.D PANVARY 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) M 558A, M.D FIRAS UNION MEMORIAL Baltimore, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar South

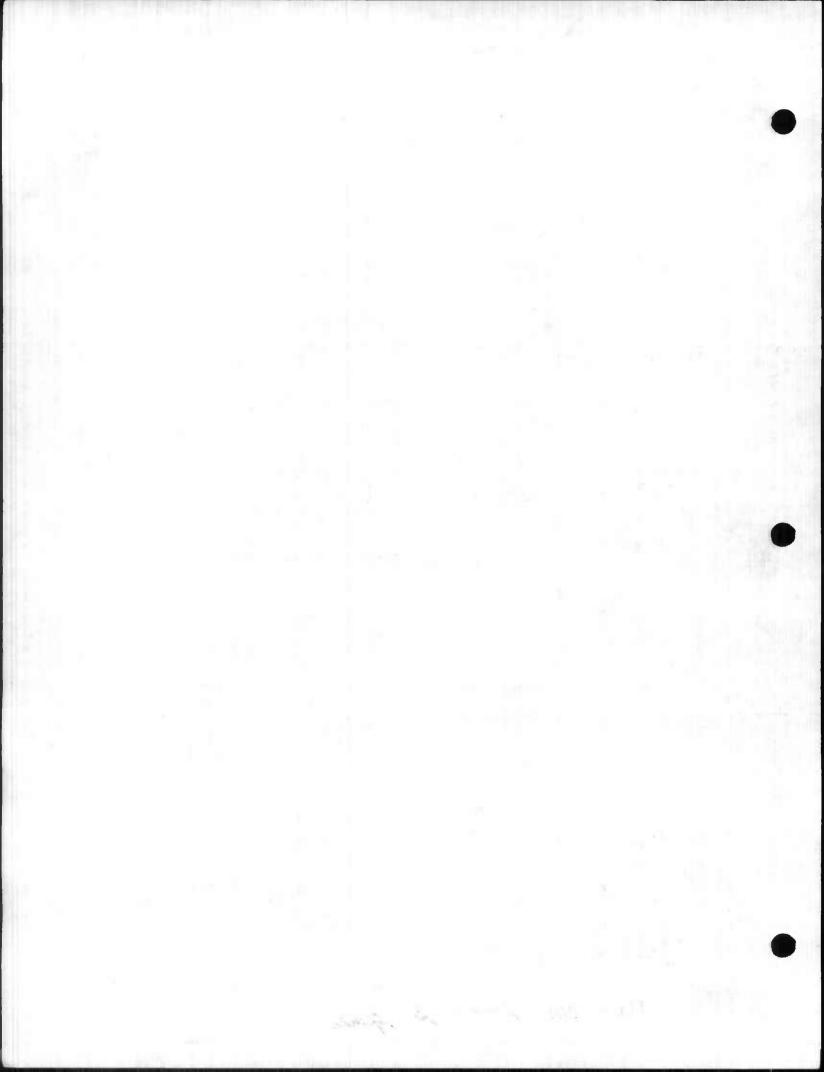
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jvw State of Maryland / Department of Health and Mental Hygiene 00-0646-510 Certificate of Death Reg. No. Frances Akehurst cedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dev **Physician** Francis Beall Akehurst FEBUARY 04,2000 7:10 A.M /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. | 8 Baltimore City 5. Sociel Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 M 2 F Director 90 212-40-6150 Perry Hall.MD Usual Residence of Deceden the Maryland 10a Steta 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11509 Cedar Lane 21087 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck White etc. 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: à 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elemantery/Secondery (0-12) College (1-4or 5+) Nursing Public Health 12 yrs. Nursing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Peges 1 and 2 should be and Mental Dallas Beal Mary Francis 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) nt of Health and : If Item 27 Is n 11509 Cedar Lane Kingsville, MD. 21087 David Akehurst 20a Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State cemetery, crematory or other plece) 1 A Burial 2 Cremetion 3 Removal from Stata Perry Hall, MD. 21128 2/7/2000 Camp Chapel Church Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility E.F.Lassahn Funeral Home Kingsville, MD. 21087 20 11750 Belair Road 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart feilure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Finel Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of): diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably Unknown 3 bengis d be det Records, p 24b. Wara autopsy findings evailable prior to Completed 24a. Wes en eutopsy completion of cause of death? Inspection page 2 The certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific. Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2□ER/Outpatient 3□ DOA Certification: To 1 Inpatient 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending t Matural invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, ferm, etreet, factory, office building, etc. (Specify) 3 4 Homicide .5 within 24 hours aft To the Funeral DI completely lilled in Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to tha cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifian 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBUARY 4,2000 O.C.M.E 30. Nama and address of person who completed cause of death filem 23a) (Type, Print) Stephen Radentz, 111 Penn Street, Baltimore, Maryland 21201 FEB 1 2000 32 Registrar's Signature 31. Dete State Registrar Sparke DHMH 16 Rev 6/95

ORIGINAL



Piease Type or Print in Black Indeible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year KATHERINE F. AMBERMAN 2000 5:55 PM FEB. 2 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore County Manor Care - Rossville 8. Date of Birth Month, Day, Year)
Jan. 15, 1910 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) 10 M ZEEF Hours Days Months Maryland Yrs. 219-58-4231 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9435 Belair Rd. 21236 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 YTS. College (1-4or 5+) Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Jasper Margaret Mulhausen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Amberman Sr. (Son) 3827 Perry Hall Rd. Perry Hall, Md. 21128 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State XIX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Michaels Ch. Cem. 2-7-2000 Baltimore, Md. 21. Signature of Funeral Service Clonses 22 Name and Address of Facility. E. F. Lassahn Funeral Home The state of 11750 Belair Rd. Kingsville, Md. 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Intervat Between Onset and Death HM hydhmias 1-2 hrs Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown DM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? llian plaskuction 1 Yes 2 No 1 Yes 20 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.0. Records. Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ? It marked other then. ? It marked other then. natural', or flems 23a or 28a-1 abov traumatic avent, in adding flaming an organism

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Baltimore, Maryland

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/Medical Examiner

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24 hours after death. Funeral Director: A

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Hospital

filled in by

completely

edical Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Pay Year) 2000

State Registrar **DHMH 16 Rev 6/95**

3//. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

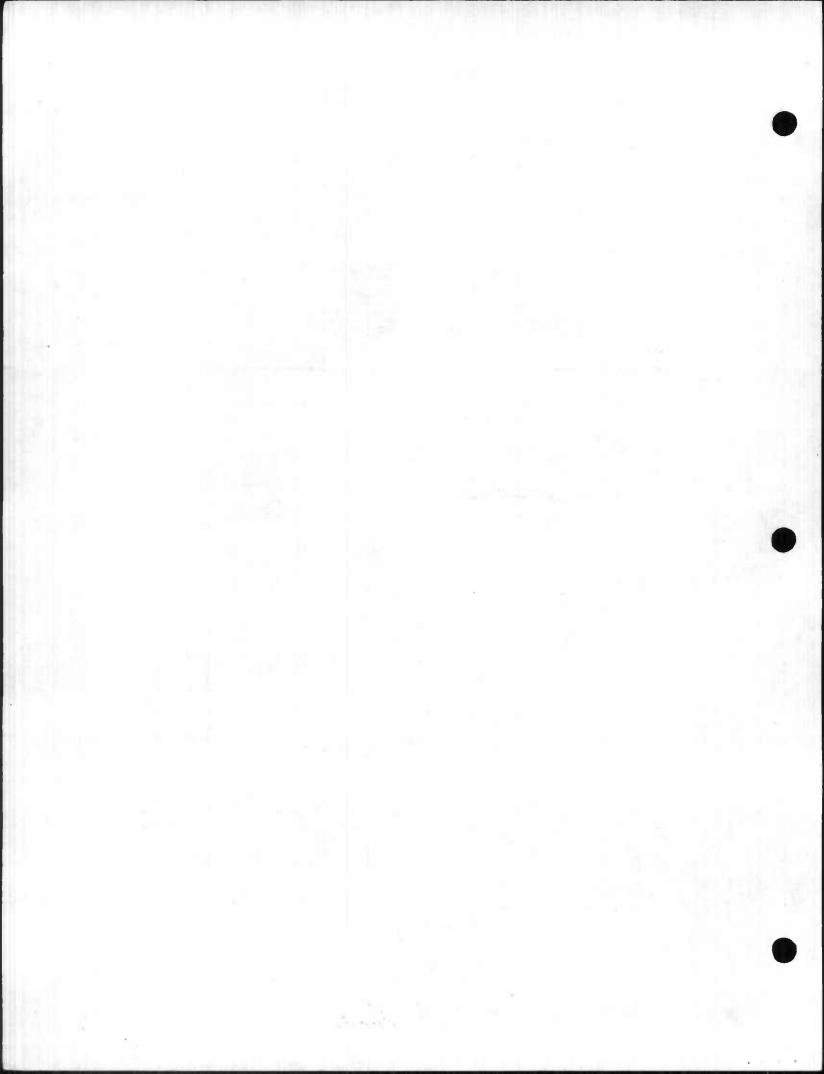
MALIKA WASEBM, 406 - EASTERN BLVD MD-

29d. Date signed (Month, Day, Year) 02-04-2000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D - 38754 .



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Year February 35 pm Irene Emma Bowen 2000 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hanes theare timore Heal If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) July 8, 190 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 M 204 Yrs. 1909 90 124-14-0754 Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 MYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 United States 820 South Caton Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Upholsterer Furniture 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edmund F. Kroneberger Rose Ella Dorsev 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Kurtz (Daughter 1617 South Ellamont Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Loudon Park Cemetery 2/7/00 Baltimore, MD 21. Signeture of Funeral Service Louis 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each limit Approximate Interval Between Onset and Death Immediate Cause (Finel Obstructive Pulmonary Oisease disease or condition resulting in death) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 POnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No check only one)

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Director

Funeral

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Director

r than "natural", or home 23e or the Medical Examiner must be r

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mertal Hygiene.

And If Rem 27 is marked other than "natural, or he way or other traumals event, pre Modical Earning my or other traumate event, pre Modical Earning.

altimore, Maryland 21215-0020

death

Examiner the burial-transit and Physician/Medical USB 85 1 signed by the attend to the detached for the Completed by Be Medical Certification: To this funeral After t S4 hours after death.
 Funeral Director: Aftiletely filled in by the fur. filled in by

The law requires that the death certificate be executed

or Attanding Physician:

Hospital

completely

State Registrar

To the \$

Division of Vital Records, P.O. Box 68760,

| 5. Wes case referred to medical | | | | 26. Place of De | eeth (C |
|---|---|---------------------|--------|----------------------------|---------|
| axaminer? 1 Yas 2 No | Hospital: | | 3□ DOA | Other: 4 Nursing | Home |
| 7. Menner of Death 1. Natural 5 Pending 2 Accident investigation | 28a. Data of Injury (Month, Day Year | 28b. Time of Injury | | Injury at Work? 1 Yes 2 No | 28d |

6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, tectory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

5 Residence 6 Other (Specify)

. Describe how injury occurred

29e. Cartifier (Check only one)

3 ☐ Suicide

4 Homicida

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner steted. 29c. License number 29d. Dete signed (Month, Day, Year)

| the | Otorro | 1 MD | |
|-------|--------|------|--|
| // // | | | |

Avenue

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 00

-02161 31. Dete filed (Month, Dey, Year)

29b. Signature and title of certifier

32. Registrar's Signature

A sup Brand

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer John, Buttersby 14:01 2000 February /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore Healthcare St. Agnes 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) (State or Foreign **Funeral** 1**X**M 2□ F Months Deys Hours Yrs. 73 Director 219-18-3507 March 26, 1926 land Usuel Residence of Decedent 10e. Steti 10b. Cour 10c City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours efter death with the Marylai ment of Health end Mental Hygiene.
ant: If Item 27 is marked other than "nature!", or items 23a or 28a-f show ury or other traumatic event, the Medical Example must be nother as Baltimore Baltimore 1 □ Yes 2 No by Funeral Director 10f. Zip Code 10g. Citizen of What Cour 12. Wes Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No ItM'es, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1□Yes 2No Baltimore, Maryland 21215-0020 Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (2)2) College (1-4or 5+) Dispatcher 17 Tather's Name (First Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be atherine 919 Vatricia Batters Joh 20e. Method of Disposition 3 □Removal from State Burial 2 Cremetion Donetion 5 Other (Specify) 21. Signature of Funerel Sarvice Licensee 23a. Perf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List only one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel MYOCARDIAL Inforction diseese or condition resulting in deeth) Examiner Coronery Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760. Pertic VICET dIFERSE Physician/Medical Due to (or es e consequence of) signed by the at d be deteched fo Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? director, page 2 should 24e. Wes en eutopsy performed? 1 □ Yes 2 No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Naturel 2 Accident 5 Pending Investigation death. 1 Yes 2 No To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide 1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number MO February 8,2000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Cator Auc Biltimore, Maryland Feinstein, mo Daniel 900

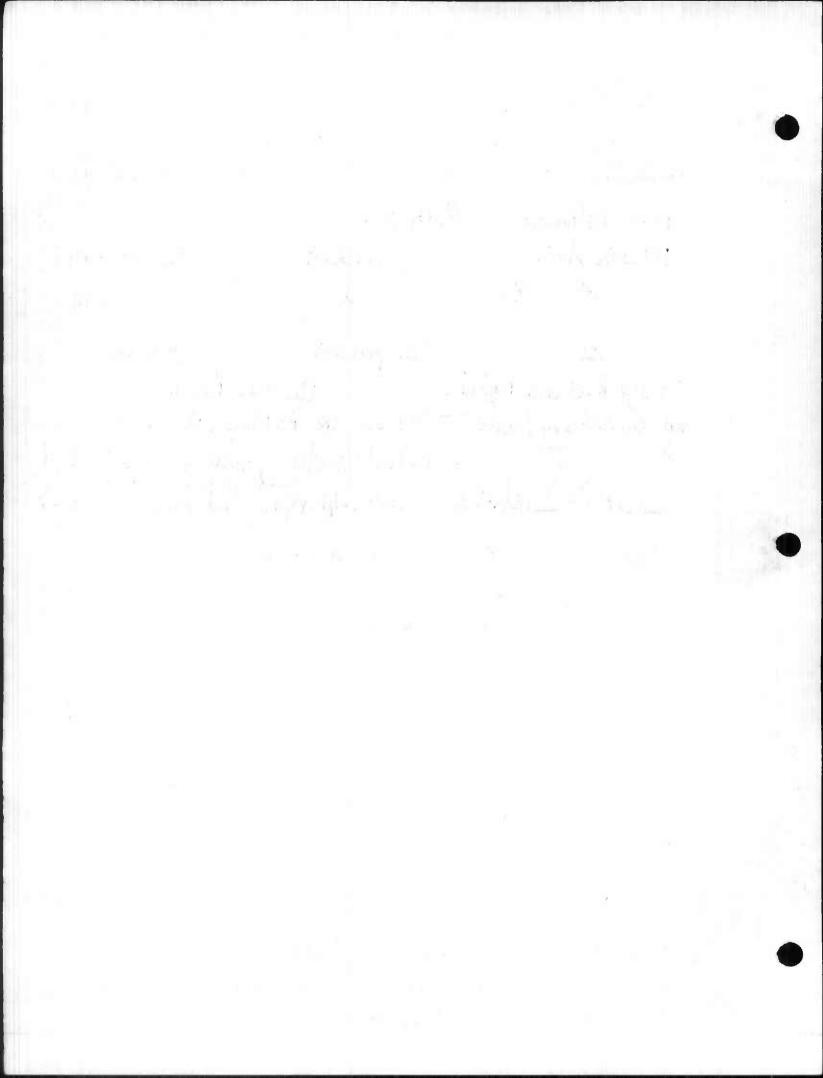
State Registrar 31. Dete filed (Month, Dey, Year)

FEB 1 1 2000

32. Registrer's Signeture

DHMH 16 Ray 6/95

Sattersby



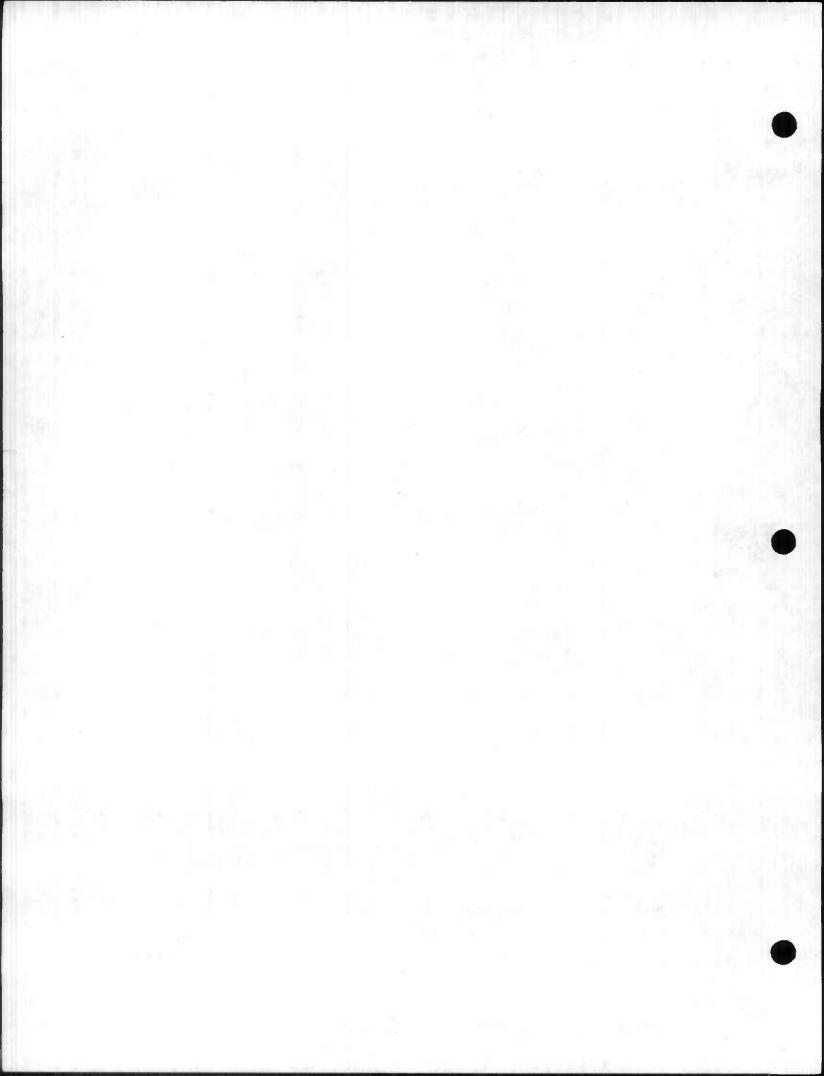
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 2, 29 per doc. G780 2/11/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Feb. Vest **Physician** 11:11 PM Victoria Lillie 2000 Batts /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Hospital Baltmore of Isaltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) **Funeral** Months Min. Days Hours 1 M 2 TF Director 295-36-4337 59 S.C. Usual Residence of Decede 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryta TY Yes 2 No Director 28s-f MD the Medical Examiner must be notifi-Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a Funeral 21216

13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 3705 Woodhaven U.S.A. 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Biack, White, etc. 1 Never Married 2 Married b 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementery/Secondary (0-12) Cotlege (1-4or 5+) 12th grade Industrial Company Machine Operator Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be n and Mental I should be traumetic Ellis Brown Sr. Hattie Mae Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Neme/Reletionship (Type, Print) saffment of Health an important if them 27 is n any injury or other 21215 Lorriane Williams-Daughter 3311 Liberty Height Ave B7, Baltimore Md Baltimore, 20b. Ptaca of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 Cramation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 2/11/2000 Baltimore Co, Md of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md Tarre 21215 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, or heart sure. List only one ceuse on each line. Approximate tntervel Between Onsat and Death **Physician** tmmediate Cause (Finat disease or condition resulting in death) /Medical hemorr Intracranial Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last as the buriaf-tran Bud Dua to (or as a consequence of) Box 68760 ettending physician Physician/Medical Due to (or as a consequence of) P.O. Part tt. Other algniftcant conditions contributing to death but not resulting in the underlying cause given tn Part f. 23b. Did tobacco use contribute to the cause of death? 94 signed by it 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy tindings available prior to completion of causa of death? page 2 should Completed 24a. Was an eutopsy certificate hes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Physician: · Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this Director: After this in by the funeral 27. Manner of Death Certification: 28d. Describe how injury occurred 28b. Time of Injury at Work? Division Attending 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Piace of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by or A after 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) February 2000 Luar 30. Name and address of parson, completed cause of death (Item 23a) (Type, Print) David Spingh Belvede 2401 West 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

Registrar

ORIGINAL



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Brown 08 2000 12:04 A.M - thruary /Medical Tr Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
2 -20-1944 4c. County of Daeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, Examiner 7. Age (In yrs. last birthday) Johns Hopkins 6. Sex, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) Funeral 10 M 2 F Months Days 247-68-5810 55 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 Yas 2 No Baltimore Director NIA Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Street . S.A Preston 21213 Items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after d. Department of Health and Mentel Hygiens. Important: if fem 27 is marked other than "natural", or fem eny injury or other traumatic event, the Medical Experiment 2008. Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2000 Specify: Black Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Trucking Company Elementary/Secondary (0-12) College (1-4or 5+) 10th grade NA Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 Slan Brown Holler 0 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type, Print) Kobert Brother 5651 Leiden Ma 140 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removel from Stete 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete Date Memorial Candallstown Mb 2-12-2000 4 □ Donation 5 □ Other (Specify) Park 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 21215 1300 Fit. U 1007 Balto, ud Wabash Avenue 234. Part. Enter the dise se, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) OTONARI NEARS Examiner Due to (or as a consequence of): Examiner physicien end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): 188 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yea 2 ☐ No þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 200 No 1 Yes 2 No To the Hospital or Attending Physicien:
within 24 hours after death.
To the Funeral Director: After this certifica
completely filled in by the funeral director; 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

State:

Baitimore, Maryland 21215-0020

Box 68760.

Division of Vital Records. P.O.

31. Date filed (Month, Day, Year) 1 1 Registrar

29b. Signature and title of contiline

29a. Certifier

(Check only one)

Medical

The 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Al, Wolfe

Johns

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

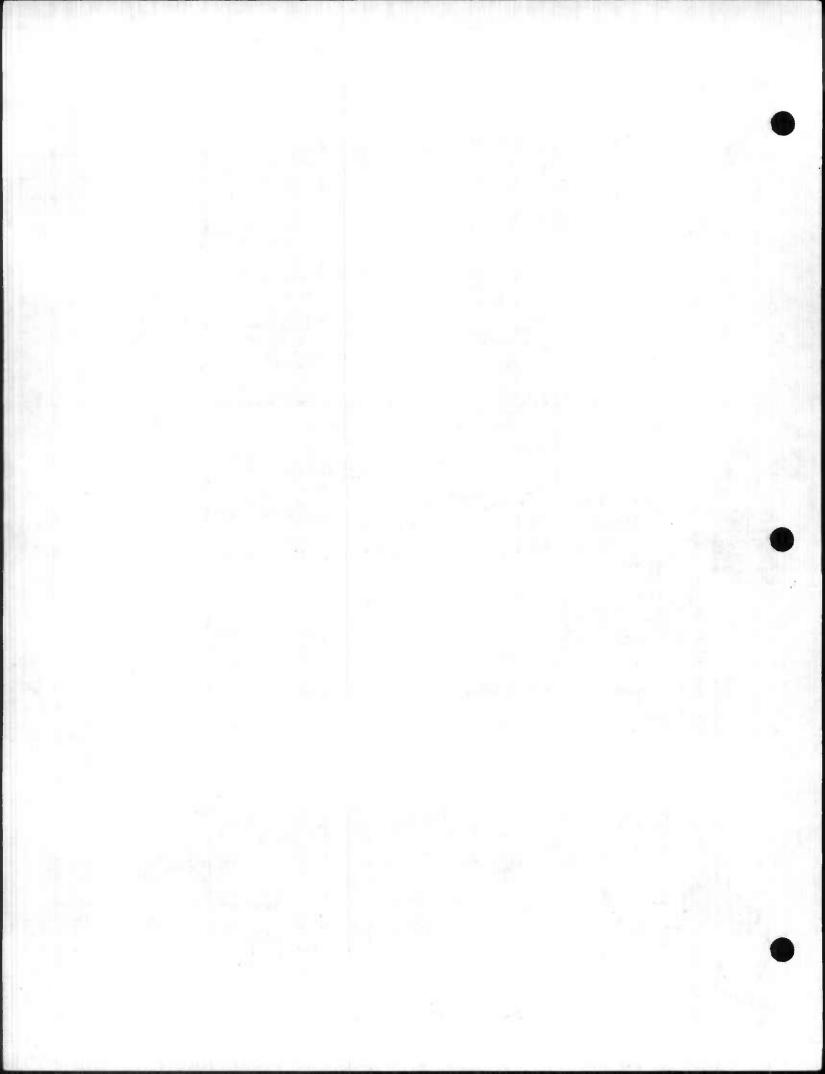
lopkins

29d. Date signed (Month, Day, Year)

Hospita

18 February

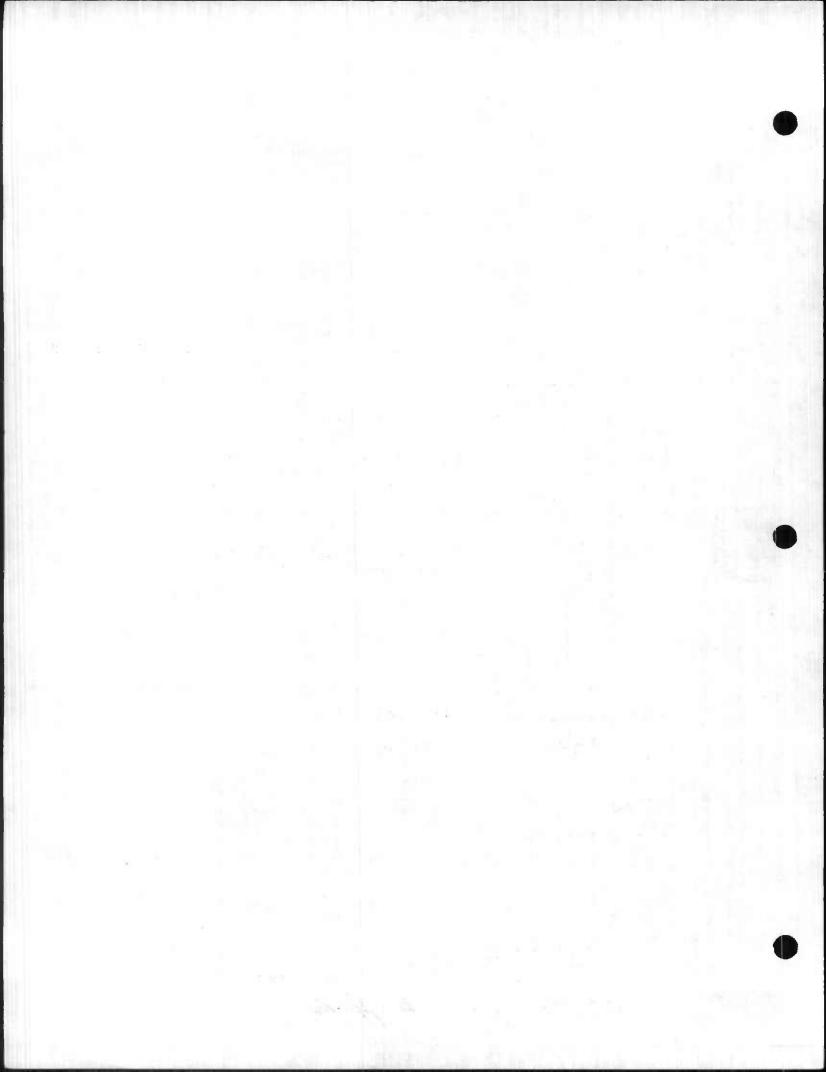
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| | | | | | Ce | rtificate | of | Death | | | Reg. No. | | | |
|--|--|---|--|---|-----------------------|------------------------------|------------|-------------------------------------|--------------------------------------|------------------------------------|------------------------------|---|---|------|
| | Physician /Medical | Decedent's Neme (First, M KENNETH A | | JR. | | | | | | Month | eath Day | 2000 | | |
| | Examiner | 4e Facility Name (If not institute 4824 GRENVII | | umber) | | | | ARBU | JTUS | | BA | LTIMO | RE | |
| | Funeral Director | 5. Social Security Number 219–50–1539 Usual Residence of Decedant | 6. Sex 1 M 2 □ F | 7. Age (In yrs. la 51 | st birthday) Yrs. | | | If Under Hours | 24 Hrs. Min. | 8. Date of B (Month, D 02-11 | irth Pay, Year) -1948 | 9. Birth Coo MA | nplace (State or For untry) RYLAND | eigi |
| sth with the Meryland 23a or 28a-1 show ust be notified at ral Director | MD BAL | | | | | | | | | | | 1 ☐ Yes 2 🔀 | | |
| | Maryland 21215-0020 nd 2 should be filed within 72 hours after design and Mental Hyglene. 27 te marked other than "natural", or frame treaumatic event, the Hydles Emerine. To Be Completed by Fune | | | | | | | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 020 | | 11. Meritel Status 1 Never Merried 2 N 3 Widowed 4 N Divor | Armed F ferried 1 1 1 Yes | Armed Forces? If Yes, specify | | | Cubi | Cuban, Mexican, Puerto Rican, etc.) | | | | o- 14. Race - American Indian, Black, White, etc. Specity: WHITE | | |
| 215-0 | | 15. Dece (Specify only hig Elementery/Secondery (0-1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | | | of Business/Industry | | | | |
| | | 12 | | | | | | | | e (First, Middl | | DISTRIBUT | 01 | |
| rylar | | RENNETH A. BOWER, SR. | | | | | | | | | | | | |
| | | ALIDA L. SHON | | | 1634 | McHENF | RY | | | TIMORE | , MD 2 | 21223 | | |
| Baitimore, | permit. Pages 1 Department of H Important: If Ner eny injury or oth once. | 20e. Method of Disposition 1 X Buriel 2 Cremeti 4 Donetion 5 Other 21. Signature of Funerel Serv | (Specify) | Stete | Peter | & Pau & Pau . Name and | er pla | Cemet | ery | 02-10 2000 | Cumbe | rland | , Marylan | F |
| 68760, | Certificate be associated ding physician and use as the burial-transit as a second as | Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | a | Due to (or a | es a consec | Quence of): | | | | | | | Interval Between | >- |
| Vital Records, P.O. Box | aw requires that the death or se been signed by the attence 2 should be detached for us pleted by Physician. | Port II. Other eignificant condu | d. White contributing to a co | death but not result | ing in the u | nderlying cau | se giv | Sch | | 1[24a. Wa | Yes 2 I | No 3 □ Pr | Were autopsy finding available prior to completion of cause | now |
| ital | ystclen: The Is certificate he director, page | 25. Was case referred to med axaminer? | ical | 20_Date of Death Dot 31 am Store of Death Dot 31 am Dot 31 am Dot 31 am Store and number SQUARE ARBUTUS 46. Cety of Death BALTIMORE BALTIMORE SQUARE 7. Age (by yrs. last birthclay) If Under 1 Year Days House Men. BALTIMORE BALTIMORE BALTIMORE SQUARE 100. City, Town or Location ARBUTUS 100. City, Town or Location 100. City, Town or Location | | | | | | | | | | |
| Division of V | After the funeral funeral | 1 Yes 2 TNo 27. Menner of Deeth 1 Natural 5 Per 2 Accident inve | 28a. Dete (More stigetion and not be | of Injury oth, Day Year) | 8b. Time of Injury | M 280 | Noi Wor | y at | | 28d, Describe | how injury o | ccurred | | |
| O. | To the Hospital or Attention 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical | 29a Certifier 1 Certifi | ying Physician: To the | ting, etc. (Specify) best of my knowle | edge, death | occurred at | the tir | ne, date an | nd place, | City or To | own, State) e cause(s) an | d manner as | stated. | |
| | To the Hospital within 24 hours a To the Funeral Completely filled | 250 Signature and title of den | al Examiner: On the band mer | pasis of examinetio | n and/or in | vestigation, in | my o | pinion, dea | ith occur | red at the time | , date and pla | ice, and due | to the cause(s) | |
| | 1 | 1 Valk | MUL | >- | | | 3 | 018 | 5 | | Feb. | 7,2 | 000 | |
| | 10, | PAUL MIL | LER 405 F | REDERICK | | | 110 | , BA | LTIM | ORE, M | D 212 | 28 | | |
| | State Registrar | 31. Date filed (Month, Day, Ye FEB 1 | 1 2000 32. | Registrer's Signetu | ro B | Spo | 2ck | 2 | | | | | | |

Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers 187

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** 02 06 2000 2:50 pm Ethelyn M Browning /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Catonsville Baltimore 8. Data of Birth (Month, Day, Year) If Under 1 Yaar | If Under 24 Hrs. | 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** Days Hours Months 1 M 2 F Yrs. 213-36-1486 74 03 24 1925 Director MD Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director 28a-f Md Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2022 Cedar Circle Drive 238 21228 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Rece - American Indien. 11. Marital Status Black, Whita, atc. 72 hours after 1 Yas 2 No 1 Never Married 2 Married 8 21215-0020 1 ☐ Yes 2 █ No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17 Fathar's Name (First Middle Lest) 18. Mother's Neme (First, Middle, Meiden Sumema) Pages 1 and 2 aboutd be III ment of Health and Mental H ant. If Item 27 is marked off jury or other traumatic even Be Roy Keizer Lillian G. Lautenberger 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harold Browning/Husband 2022 Cedar Circle Drive, Catonsville, Md21228 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) Entombment Loudon Park 02 10 Baltimore, Md 22. Nama and Addrass of Facility
Sterling Ashton Schwab Funeral Home, 21. Signature of Funeral Sarvice Licensee Edmondson Avenue, Balto, 23e. Pert1. Enter tha disaasa, or complications that caused tha deeth. Do not entar the moda of dying, such es cardiac or raspiratory errest, shock, or haart failura. List only ona causa on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting In daath) /Medical rigoroslist infordin 3/25 **Examiner** Dua to (or as a consequence of): Examiner Aproselecti Controvosela Disea ician and buriel-transit Sequentially list conditions, if any, leading to immadiate causa. Entar Undartying Cause (Diseasa or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): physician s the buriel Box 68760. Physician/Medical Dua to (or as a consequence of): for use P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 2 No 3 | Probably 4 | Unknown Hyse lenon Be Completed by Records, P S of Circhnovarul sucht 24b. Wara autopsy findings availabla prior to completion of causa of deeth? 24a. Was an autopsy performed? The law P.s. phene Voorlo Disco 1 Yes 2 HO t Ves 2 No of Vital 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: Wursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No this funeral 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 1 Metural 5 Pending death. 1 Yes 2 No invastigation 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Certifier edical within 24 hor To the Fune completely fi (Check only one) \$ 29d. Deta signed (Month, Dey, Year) 29b. Signature and titla of certifier 29c. License number 7-2000 D349T1 30. Nama and address of person the complated causa of death (Item 23a) (Type, Print)
405 Field Red Sunk 100 Commontary 7, 278 Just 100 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie AMEND ITEM: #18 PER F.H. G780 2-22-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death 5130PM Year Month **Physician** Bozarth 4b. City, Town, or Location of Death nuc 2000 /Medical 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Frunder 24 Hrs. 8. Dete of Birth (Month, Day, Year) 1914 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Deys 178-01-0967 1 M 2 F 85 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Baltimore 25a-f Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 707 Maiden Choice Lane #9217 21228 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: "natural", or thams: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Stetus Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Specify: White 1 Yes 2♥ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Social Security Adm. System Analyst 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 80 ELSIE HOFFMAN Joseph Knebel Elsie Horrmann 19a. Informent's Neme/Retetionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryanne Bongiovani (Daughter) 10527 Dorchester Way, Woodstock, MD 21163 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or Woodlawn Cemetery 2/12/00 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete ntervel Betwe Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical naummia Examiner Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical Due to (or as e consequenca of): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Sep5,5 by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 TYes 2 No 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: tnjury et Work? An Hospital or Attention 24 hours after death. 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide

Division of Vital Records, P.O. Box 68760,

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filed within

Hygiene.

Pages 1 and 2 should be flument of Health and Mental Hisant. If Rem 27 is marked oth

that the death certificate be executed

certificate Physician:

this

After

completely

within 2 To the

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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

State Registrar

edical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signeture and title of certifier

7: chack Gallag

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Lex

2000

St. A snes Haspita

32. Registrer's Signeture

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

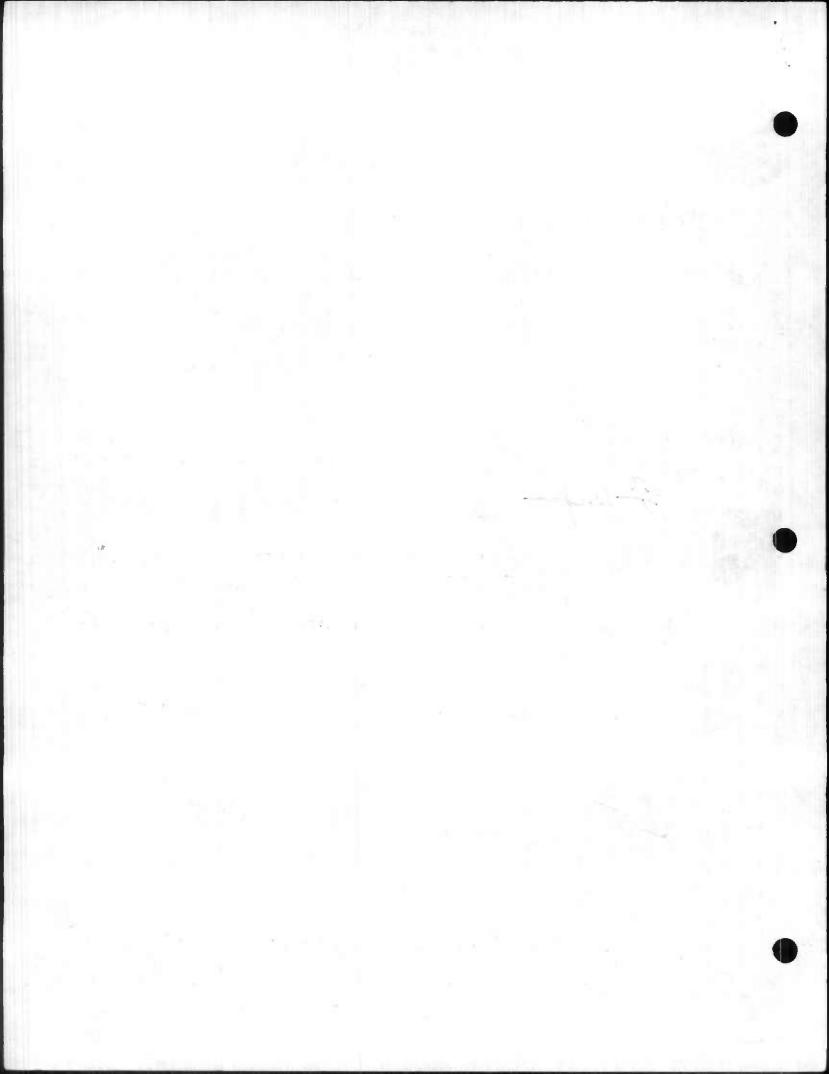
29d. Dete signed (Month, Day, Year)

to Ave Beltome 10 21229

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| Physician /Medical | 1. | Decedent's Nama (First, Mi | | - | | | | | | | | Reg. No. | | | | |
|--|--|--|--|--|--|---|--|-----------|--|------------------------|---|--|---|--|--|--|
| | | Decedent's Name (First, Min | ddle, Las | 1) | | | | | | | 2. Data of Do | | v | Year | 3. Time of De | |
| THEGICAL | | James | Rus | sell_ | Cu | tting | | | | | Jan | 19 | 20 | 000 | 2:55 PM | |
| Examiner | 40 | Facility Name (If not institu | tion, give | street and number | er) | | | | 4b. City, To | own, or Lo | ocation of Dear | th 4c. | County | of Deeth | | |
| | | 3311 River | r Cres | scent Drive | е | | | | Ann | apolis | S | | Anne | Arund | el el | |
| eral ctor | | Social Security Number 214–46–0628 | 6. Se | x 7 ∑M 2□F | Age (In yrs. la 97 | st birthday) Yrs. | Months Months | Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, Di Mar. 2 | rth ay, Year) I. 190 | 02 | 9. Birthp Coun | laca (State or Fo try) Ohio | |
| at, or Hems 23s or 23s-f show Examiner must be notified at by Funeral Director | - | ual Residence of Decedent | | | | | | | | | 1 | | | | | |
| | 10a. State 10b. County 10c. City, Town or Location | | | | | | | | | | | 1 | 0d. Inside City L | | | |
| | Maryland Anne Arundel Annapolis | | | | | | | | | | | | 1 □ Yes 2)(| | | |
| | | 10e. Street and Number 10f. Zip Code 3311 River Crescent Drive 2140 | | | | | | ⁄₁∩1 | | | | | /hat Coun | try? | | |
| | 11. | 11. Marital Status 12. Was Decedent Ever in Armed Forces? | | | | | 21401 or in U.S. 13. Wes Decedent of Hispanic Origin? (Specifity Cuban, Mexican, Puerto Ric | | | | | Ifv Yes or No- 14. Ra | | | ace - American Indian, | |
| | | 1 Never Merried 2 MM 3 Widowed 4 Divord | | Armed Force 1 [V] Yes 2 [If Yes, Give Year or Date: | □No | | lf Yes, spe 1 ☐ Yes | | | | Rican, atc.) | | Specify: | k, Whita, | hite | |
| Completed | | 15. Deced | | | | 16a. Dece | dent's Usu | el Occup | pation | et of work | ina | 16b. K | ind of Bu | siness/Inc | lustry | |
| ple | | (Specify only hig Elementery/Secondary (0-12 | - | College (1-4c | or 5+) | life. | DO NOT u | se retire | d) | N OF WORK | my | | | | | |
| No. | | | | 5+ | |] | Profess | sor | | | | U.S | S.N.A. | | | |
| Be | | Father's Neme (First, Midd | lle, Last) | | | | | | 18. Moth | er's Nam | e (First, Middle | , Maiden | Sumeme | 9) | | |
| 0 | | Hurlbut Bar | mes C | utting | | | | | I | ouise | Smith | | | | | |
| | 19 | a. Informant's Neme/Relation | | | | 19b. Maili | ng Address | s (Street | and Numb | er or Run | al Route Numb | ber, City o | or Town, | Stete, Zip | Code) | |
| | | James Cuttin | ig Jr | . / Son | | 4835 | Calver | t St. | . NW Wa | shine | ton D.C. | 2000 | 7 | | | |
| | 20 | a. Method of Disposition | | | 20b. Pla | nce of Disponentery, cre | osition (Na | me of | 201 | | Deta | 20c. Lo | ocation - (| City or To | wn, Stata | |
| njury or | | 1 Burial 27 Cremetic | on 3 □F | Removel from Ste | ta | Linco | | | | io | 2-04-00 | Propi | h.md | , Mary | al and | |
| | 21 | Signature Funeral Servi | | | Tt. | | 2. Name ar | | - | in . | | | | | | |
| ouo | - | 14. 1 | 10 | | | - | | | | Jo | hn M. Ta | - | | | | |
| | - | la. Flash. Enter the disease, shock, or heart failure. | fr | | | | | | | | ster St. | | olis, | Md. 2 | 21401 | |
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| Examiner | | sulting in death) | ſ | Sev. | Due to (or Due to (or | | | | | | disen | | | | Prims Yrs. Yrc | |
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Dete of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death 24, 2000 11:00 AM JANUARY ALLEN B, CLINEDINST JR 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street and number) Baltimore Rosedale 8224 Dorset Avenue If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) NAM 2□ F Months Deys Yrs. 74 12/05/1925 216-20-7958 Usuel Residence of Decedent Baltimore 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Rosedala 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8224 Dorset Avenue 21237 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Stajus Bieck, White, etc. WWES 2□No WWII West or Detes:/44-8/46 1 Navar Married 2 Married 1□Yes 2□No 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Realtor Real Estate Sales 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame Allen B Clinedinst, Jr Eleanor M. Clinedinst 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Allen B. Clinedinst, III 200. Method of Disposition 1912 Ridgewood Court, Hampstead, Md.

20b. Pleca of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funarai Sarvice Licensee 22. Nama and Address of Fecility State Anatomy Board-655 W.Baltimore Street Joseph B. Vansant (per VR)

Baltimore, Md. 21201

23e. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediata Causa (Finel disease or condition resulting in deeth) EREBRAC TUROR Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of) Dua to (or es s consequenca of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the causs of death? DUORDER 1 Yas 2 No 3 Probably 4 Unknown 24b. Wera sutopsy findings svelleble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? VASCULAR DECIDENT BREBRO ARTOR 25. Wes cese referred to medicei exeminer?
1 ☐ Yes 2 → No Kore 26. Plece of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 200 Outpetient 1 tnpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division of Vital Records,

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Physician

/Medical

Examiner

Director

Funerai

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Certification:

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Registrar

29e. Cartifier

(Check only one) A

Director

Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic avent, the Medical Examiner must be notified at

any injury or o

Physician /Medical

Examiner

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite

Saltimore, Maryland 21215-0020

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death

ospital or Attanding Physician: hours efter death. uneral Director: After this certifica 24 hours Hospital within 2. To the F the life

> 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SISHORE

29b. Signatura and title of certifian

UD YAVAR MO 32. Registrer's Signeture

9600 NORTH OT BUD.

038635 (94)

29d. Dete signed (Month, Day, Year)

FORF HOWARD

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and dua to the ceuse(s) end menner stated.

31. Dete filed (Month, Day, Year)

FEB 1 1 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Physician Simon Canty 5:22 PM 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland System Medeul Baltomore If Under 1 Year | If Under 24 Hrs.
Months | Deys | Hours | Min. 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Director 249-38-2670 Usual Residence of Decedent 10 S.C the Maryland 10a State 10b. County 10c City Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Manylan and of Health and Mental Hyglene.
Intil if Itam 27 Is marked other than "natural", or Homa 23a or 28a-f show my or other than "natural" and other traumitic avant, its Manies and its mast be notified at my or other traumitic avant, its Manies. 10d. Inside City Limits XXYes 2 No Director MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U . S . A .

14. Race - American Indian, Black, Whita, atc. Funeral 2103 Edmondson 21223 Ave 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Detes: XXNever Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Gaint Food Store Bakery 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Simon Canty Martha Joe 19a. tnformant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Dickey-Niece 902 Whitmore Ave, Baltimore Md 20a. Method of Disposition
1 by Bonal 2 ☐ Cremation 3 ☐ Removel from State
4 ☐ Constion 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o Western Star Cemetery 2/14/2000 Baltimore, Md 22. Nama and Addrass of Fecility 21. Signature of Funerat Service License March F/h West
4300 Wabash Ave, Baltimore Md
or hear feilure. List only one cause on each Line

March F/h West
4300 Wabash Ave, Baltimore Md 21215 Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease outcondition resulting in death) pulmonary Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burlat-transit Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot) Box 68760. Due to (or as a consequence of): USB 88 Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records. þ The law requires 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed certificata has b lirector, page 2 s 1 Tes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was casa referred to medical examiner? 89 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this s 28b. Time of tnjury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation or Attanding Netural 24 hours after death.

Funeral Director: After the funeral billing in the funeral billing i 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

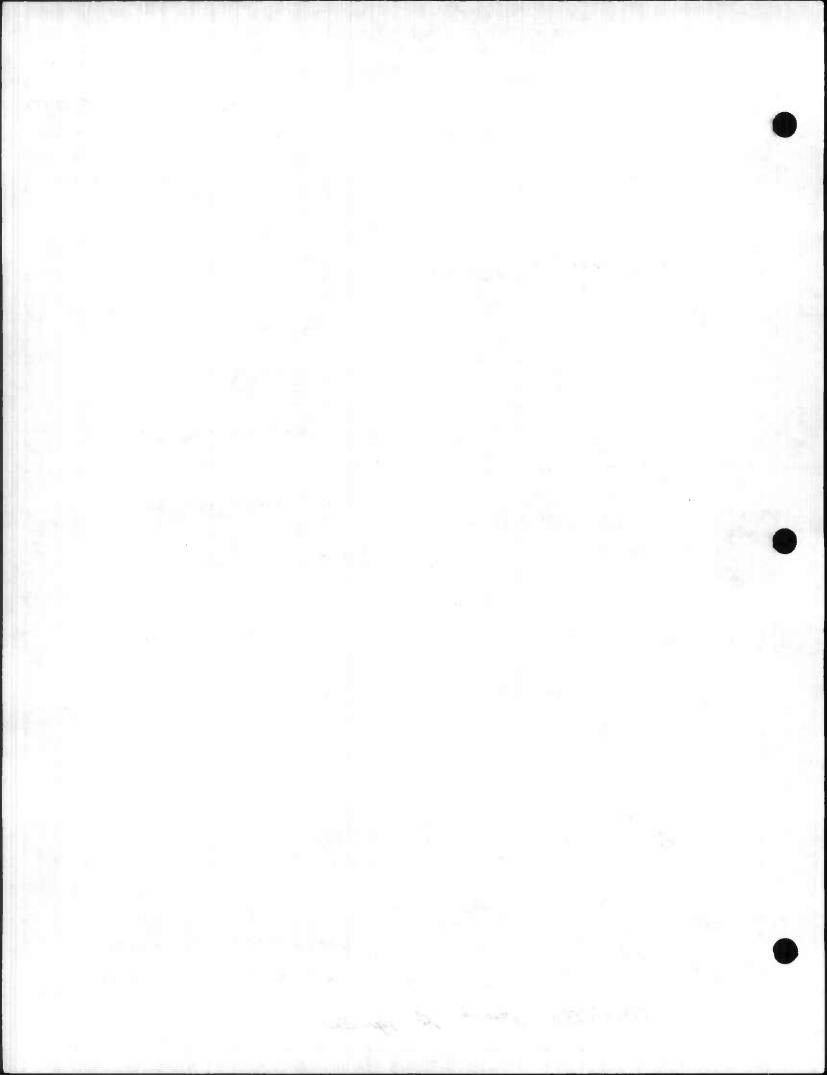
| Redical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier pietely (Check only one) To the \$ 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 00052745 02/08/2000 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To seph P. Regan 22 S. Gneen Baltomore, MO St. GNERME 31. Date filed (Month, Day, Year) FEB 1 1 2000 32, Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Date of Death 3. Time of Death _Month 130 Cm. February BEATRICE **AMELIA** CLEMENS 2000 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth ARUNDEL SURNIE ANNE HOSPITAL (BR+11 ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Days Hours Min. 1□ M 2√F 216-20-8890 71 Vrs 1928 Washington D.C. Usual Residence of Decedent 10a. Stelle 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel County Crownsville 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 410 Serpentine Road 21032 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 ₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife. Home Owner 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond T. Jacobs Mary Anderson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Clemens 410 Serpentine Road, Crownsville, Md. 21032 (Son) 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 2/12/00 Glen Burnie, Md. 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee Name and Address of Facility. McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 23a. Pert1. Enter the disease, or complications that fauved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel MyscarolAL 2 weeks disease or condition resulting in deeth) Due to (or as e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of) Due to (or as a consequence of) Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1□Yes 2□ No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? palinom 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manmer of Death 28b. Time of 28c. fnjury at Work? Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and piaca, end due to the cause(s) and manner steted.

The law requires that the deeth certificate be executed Box 68760, P.O. Division of Vital Records,

and ettending physician for use as the burie the signed by the et ald be detached for certificata has Hospital or Attending Physicism: 24 hours after death.
Funeral Director: After this certifica filled in by the To the Hospital
within 24 hours
To the Funeral E
completely litled

Physician

/Medical

Examiner

Funeral

Director

28a-f show itams 23a or 28a-f shov incr mast be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Macinal Experience and injury or other traumatic event, the Macinal Experience pice.

Pagas 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than '

Physician /Medical

Examiner

Physician/Medical

ģ

Completed

Be

10

Certification:

Medical

29a. Certifier

29b. Signeture and title of certifier

Maryland

altimore,

ENTRIC!

Director

by Funeral

Completed

Be

filed within 72 hours after death with the Marylend

State Registrar

1 2000

29c. License number

29d. Date signed (Month, Dev. Year)

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date lied (Month, Day, Year)

301 Hrsin 32 pegistrer's Signature

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dav Month **Physician** 0035 pm Charles H. Crafton .00 500 /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HEAL N/A AGNES 7#CARE 5/. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F Months Days Hours 216-07-7639 Maryland Director 81 Aug. 30, 1918 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic svent, the Medical Examinal must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 Bardswell Road 21228 United States death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, Whita, etc. 11. Marital Stalus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or from any injury or other traumetic svent, the Medical Example page. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Owner Tavern 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Charles Joseph Crafton Rose Ε. Varnhorn 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Crafton/Son 2921 Stockton Road Phoenix, Maryland 21131 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 2/11/2000 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. thomas uanita 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burla Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eigned by ğ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 certificate has 1 Yes 2 No 1 Yes 22 No 25. Wes case referred to predical examiner? 89 26. Place of Death (Check only one) 1 Yes 2016 Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 (Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Day Year) 27. Manner Double 28c. Injury at Work? 28d. Describe how injury occurred Cartification: 1 Chatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide after A edical 29e. Certifier 🖆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(a) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 24 To the To To the F 29b. Signeture and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 16 Rev 6/95 31. Date filed (Month, Date

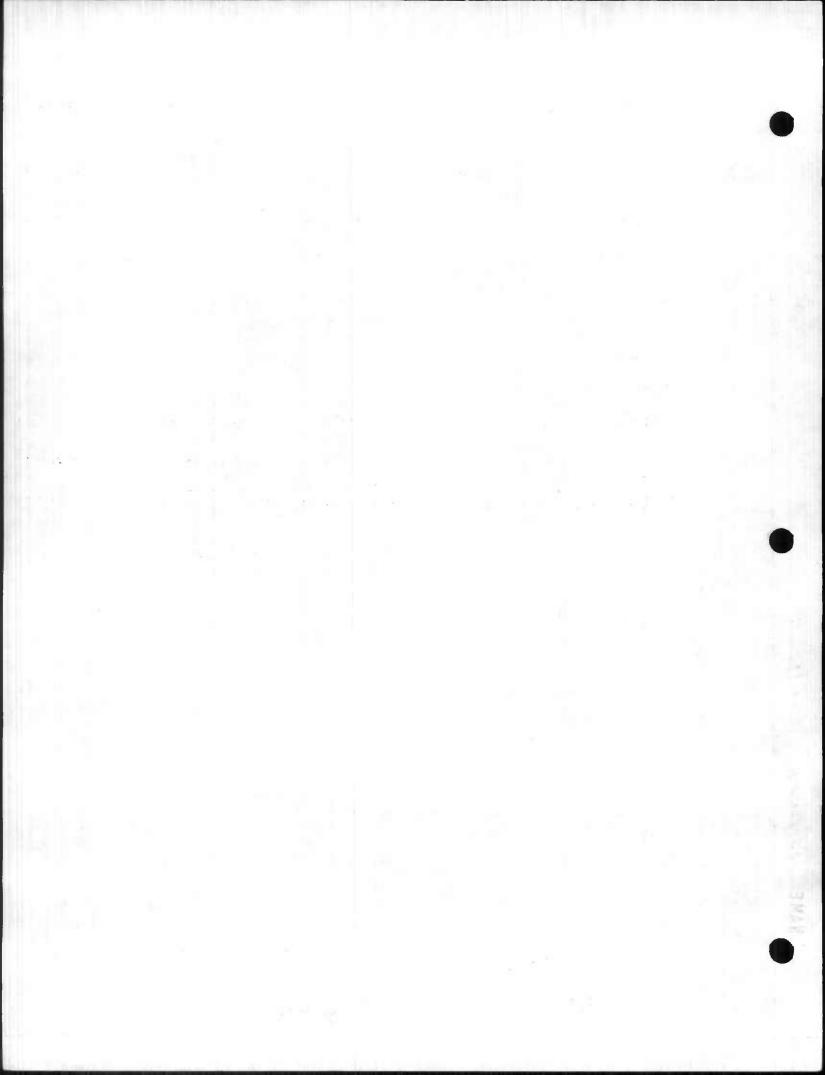
Maryland 21215-0020

Saltimore.

10 HNSON

900 CATON AVE, BALTIMORE, MD 21229

30. Name end address of parson who completed/cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey 9 3. Time of Death Year Month **Physician** THEODORE H CUNEO 10:00 AM 2000 February /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Sauare 5. Social Security Number 6. Sex OSE dale If Under 24 Hrs. 8. [enter | thday | If Under 1 Year 8. Dete of Birth (Month, Day, Year) st 23 1914 HOSPITAL Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1X M 2□ F 215-07-3279 85 Director Maryland Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 ☐ Yas 2 No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 708 Eastern Ave. 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status XTYes 2 No If Yes, Give 1 Never Married 2 Merried White altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify à 3 □ Widowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 7th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be and Mental Louis Cuneo Crescentia Pages 1 and 2 should 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) mportant: If ham 27 any injury or other to Doloris Allen 813 Dorsey Ave. Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removei from Stete GarrisonForestVACemetery 2/16/2000 Owings Mill 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Essex pications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel · Acute Respiratory Failure disease or condition resulting in deeth) **Examiner** Examiner Preumonia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 25 No 3 Probably 4 Unknown Bronchial asthma, Chronic Obstructive Be Completed by Records, 24b. Were autopsy tindings evailable prior to 24a. Wes en eutopsy performed? Pulmonary Disease completion of cause of death? 2 17 No Colon Cancer 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending investigation 1 TYes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted. 29e. Certifier completely (Check only one) within 2 ş 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Za 9000 Square Drive Baltimore, MD 2/237

State Registrar

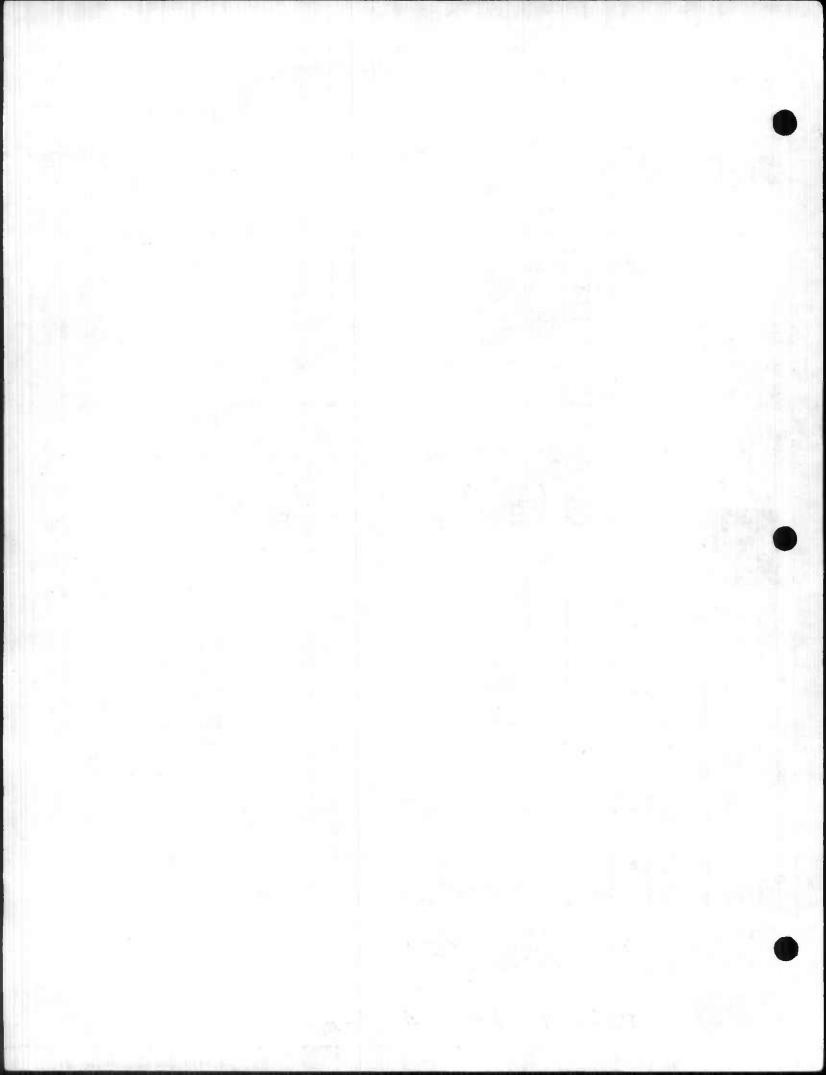
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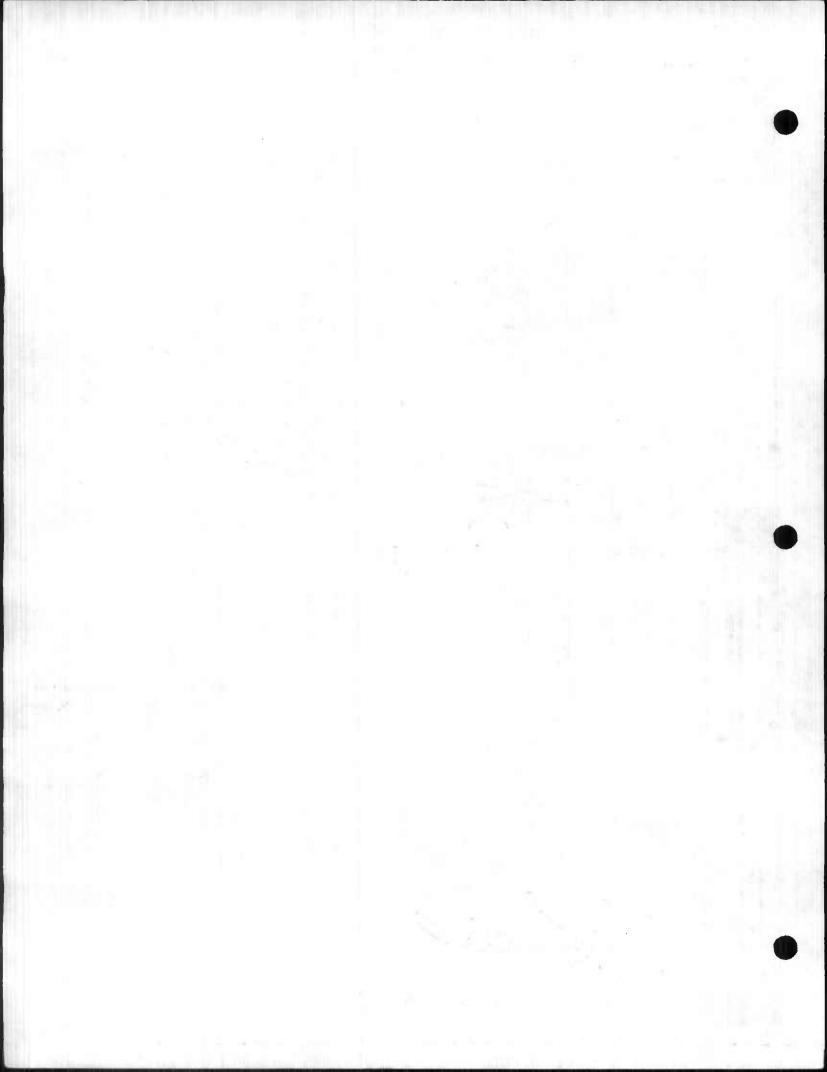
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32. Registrer's Signeture



00-0721-003 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | 1. Decedent's Nama (Fil | rst, Middle, Las | et) | | | te of | | 2. Data of De | | Mass | 3. Time of Death | |
|-------------------------------|--|--|---|-----------------|----------------------------------|----------------------------------|---|--------------------------------------|-------------------------------|--|--|--|
| cian Iical | GERALD | | ALLEN | | CRAI | G, SR | | Month FEBRUA | RY 7, 20 | Year 00 | 3:20P.M. | |
| ier | 4a Facility Name (If not | institution, give | street and number) | | | 4 | 4b. City, Town, or I | Location of Deat | | y of Death | | |
| | 1004 LANGL | | | | | | GLEN BUF | | | ARUNDI | | |
| | 5. Social Security Numb | | ex 7. Age | 38 | Yrs. Month | der 1 Year s Deys | If Undar 24 Hrs. Hours Min. | 8. Dete of Bi (Month, Di FEB 3 | rth ay, Year) , 1962 | 9. Birthpl Count PENNS | ace (State or Fore ry) SYLVANIA | |
| | | . County | | 10c. City, T | own or Location | | | | | 10 | d. Inside City Limi | |
| | MARYLAND A | NNE ARU | NDEL | GLEN | BURNIE | | | | | | 1 □ Yas 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | |
| | 10e. Street and Number | | | | 10f. 2 | Zip Code | | | 10g. Citizen of | What Count | iry? | |
| | 1004 LANGLE | Y ROAD | | | | 1060 | | 1 | U.S.A | | | |
| | 11. Marital Status 1 Never Married 3 Widowed 4 | | 12. Was Decedent I Armed Forces? 1 🔯 Yes 2 🗆 No. 18 Yes, Give Year or Detes: | | - | 2 No | lispanic Origin? (S an, Mexican, Puart Specify: | pecity Yes or No o Rican, etc.) | | ce - America eck, White, a fy: WHI | ilc. | |
| | | Decedent's Ed | | 1 | 6a. Decedent's Us | sual Occup | ation during most of wor | tina | 16b. Kind of B | Businass/Ind | ustry | |
| | Elementary/Secondary | | College (1-4or 5 | | life. DO NOT | use retired | d) | n#iy | | | | |
| | 12 | Adidde 4 - 11 | | | SPRINKLE | R FI | TTER | (F2 04' A '' | FIRE PI | | CION | |
| 1 | 17. Father's Name (First | | CDATC | | | | 18. Mother's Nan | | , Maiden Sumai | | MED | |
| 1 | HAROLD 19a. Informant's Name/ | | CRAIG | | 19h Maitino Addro | se (Strant | JACQUEL and Number or Ru | | er City or Tour | | INER Codel | |
| | TAMMY CRAI | | | | S MIEHE SEAN | | ROAD, GL | | 3 1 2 | | | |
| | 20a. Method of Dispositi | on | | 20b. Place | of Disposition (A | leme of | LLC | Dete | 20c. Location | | | |
| | 1 ☐ Burial 2 ☐ Cn 4 ☐ Donation 5 ☐ | Other 1 | Removal from State | | atery, crematory of APEAKE CI | | ION CTR | 2/11/ | STEVENS | SVILLE | , MD | |
| ı | 21. Signature of Flitheral | | | OHEO | | | and Francisco | | FUNERA | | | |
| | D / X | 4, | HORL | | 1 SECO | ND AV | ENUE, S. | | | | | |
| 1 | 23a, Part1. Enter the di shock, or heart-leg | ase, or comp | lications thet caused | tha daath. [| | | | | | , | Approximate Intervet Between | |
| | resulting in death) Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injury) | ns, liate | b | | consequence o | NARY | ARTERY A | RTERIOS | CLEROSI | S | | |
| | that initiated events resulting in death) Last | 1 | d | Oue to (or es | e consequence of | n): | | | | 1 1 1 | | |
| | Part II. Other significant | conditions co | ntributing to death bu | rt not resultin | g in the underlying | cause give | en in Pert I. | 23b. Did | tobacco usa co | ontributa to | the cause of deal | |
| | | | | | | | | 1 🗆 | Yaa 2□ No | 3 Prob | ably 15 Unknown | |
| | | | | | | | | | an autopsy ormed? | CON | re autopsy finding illable prior to appletion of cause | |
| ı | | | | | | | | . 96 | ν | | leeth? | |
| ļ | 25. Was case referred to | medical | | | | | 26. Place of Dea | | Yes 2□No | 112 | Yes 2□ No | |
| 25 | examiner? 1∑Xres 2 No | + | Hospital: | nt 2 ER | /Outpatient 3□ (| DOA Oth | or. | | 111111 | her (Specify | ,) | |
| | | Dondon | TID Inpatient 2 LENOUIPatient 3 L DOA 4 LI Nursing Home 5 LAN | | | | | 28d. Describe | ribe how injury occurred | | | |
| | 2 Accident | Pending investigation | | rv - At home | , ferm, atreet, fect | ory, office | | 28f. Location (City or To | (Street and Num wn, State) | ber or Rura | Route Number. | |
| 2 | 1 Natural 5 [2 Accident | | 28e. Place of Injubuilding, etc. | | | | | | | | | |
| | 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide | investigation Could not be determined | 289. Place of Inju | f my knowled | | | | | | | | |
| | 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide | investigation Could not be determined Cartifying Physical Fram | building, etc. To the best of the basis of | f my knowled | and/or investigetion | | pinion, death occu | | | , and due to | the cause(s) | |
| modical cel illication: 10 pe | 1 SNatural 5 [2 C Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 1] | investigation Could not be determined Cartifying Physical Fram | building, etc. To the best of the basis of | f my knowled | and/or investigetion | on, in <i>m</i> y o _l | pinion, death occu | rred at the time, | date and plece | , and due to | the cause(s) Dey, Year) | |



State Registrar

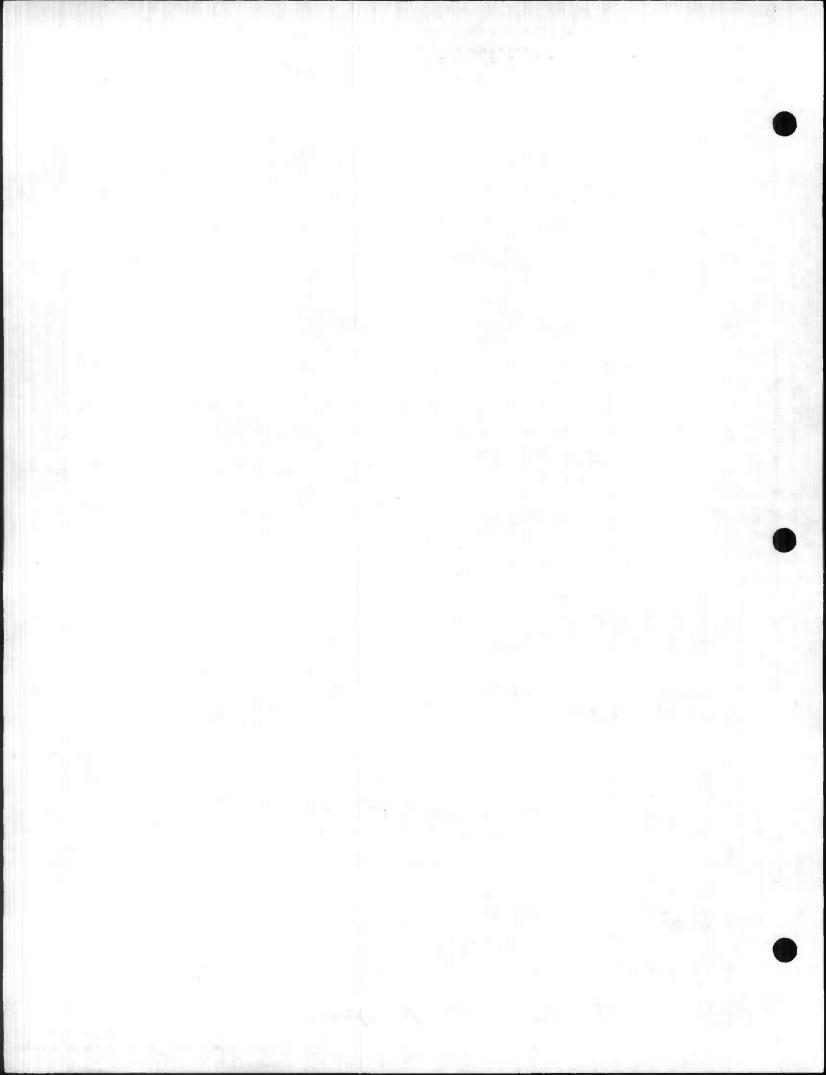
enn 31. Dete filed (Month, Day, FEB Year) 2000

30, Nama and address of person who compare

hutemo 32. Registrar's Signeture

use of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

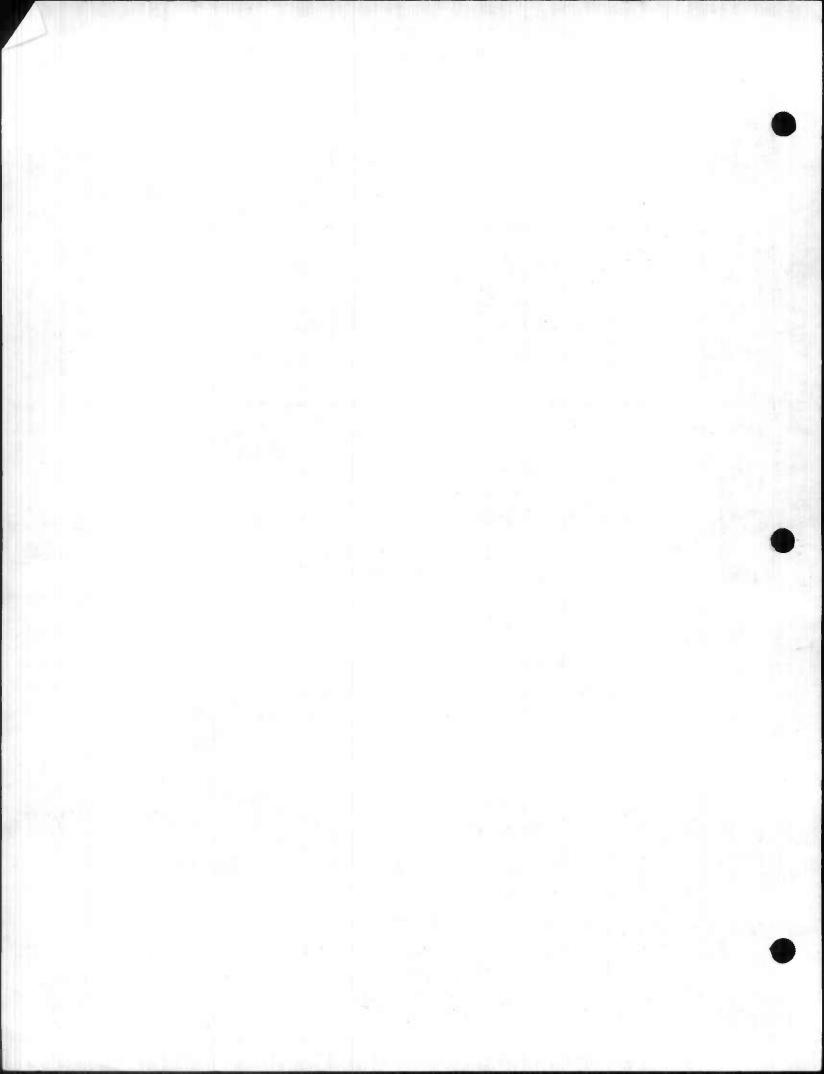


Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Physician CORLIAGO /Medical 4a Facility Nama (If not institution, giva street and number) ac. County of Death 4b. City. Town, or Location of Death Examiner HIMOR 210 If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 498-14-6368 Usual Residence of Decedent 1 M 2 DF Yes Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Rema 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or item only injury or other traumatic event, the Medical Examinations. Black, Whita, atc. ☐ Yes 2 X No If Yas, Giva 1 Never Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: Completed by 3 Widowed 4 □ Divorced Year or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 10me 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be neodore 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Baltimore, EUD. 20b. Place of Disposition (Nema of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AIP. 2000 22. Nama and Address of Facility 21. Signature of Funaral Service Licensee EVails FULLRAV Chasel limonium 23a. Parti. Entar the diseasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onset and Death Physician /Medical Immediate Cause (Final CANCEY months 0 disease or condition resulting in death) Examiner Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Dua to (or as a consequence of): Dua to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this certificate has 2 X No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case refarred to medical axaminer? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation Natural 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as staled. | Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number 2520 of person who completed curse of death (Item 23a) (Type, Print) 16-BMC N. Charles St. 67 101 e Begistrar's St (Month, Day, Year) State 11

DHMH 16 Rev 6/95

Registrar

2000

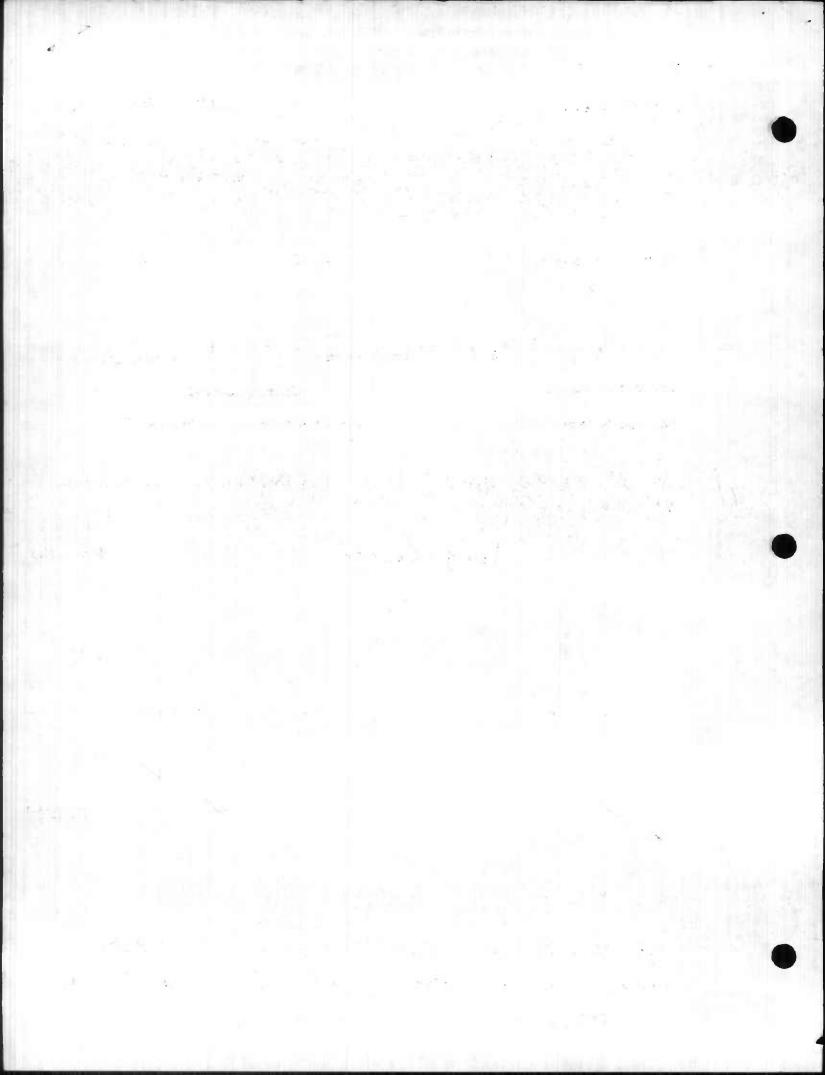


Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#26 perPhyG780 2/11/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY 9, 2000 **Physician** JEFFREY DEJESUS 6:00 AM · /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4 Chester Circle Glen Burnie Anne Arundel If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1⊠M 2□ F 44 Months 200-44-7260 Director PA April 4, 1955 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10s. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or frams 23s or 28s-f show traumstic event, the Medical Examiner must be notified at MD N/A Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3539 Horton Avenue Funeral 21225 death USA 14. Race - American Indien, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever In U,S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give X Bleck, White, etc. permit. Pages 1 and 2 should be filled within 72 hours effect Department of Health and Mental Hygiene.
Important if flow 77 is marked other than "natural", or there any injury or other traumstic event. Its Medical Ference 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 truck driver transportation

18. Mother's Neme (First, Middle, Maiden Sumente) 17 Fether's Name (First Middle Last) Be Francisco DeJesus Shirley Goodwin 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Colleen DeJesus/wife 3539 Horton Avenue Baltimore MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from Stete 4 X Donetion 5 ☐ Other (Specify) 21. Spendum of Eurorel Service Licenzoll Nonald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel lo months UNG a4 Cer disease or condition resulting in deeth) Examiner to (or es s consequence of) Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): the death certificate be execu the attending physician P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobscco use contribute to the cause of desth? signed by I 1 200 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Was an autopsy peen 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certific Be 25. Wes case referred to medicel exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 M residence 8 Mother (Specify) Mother - i m - law Residence 1 | Yes 2 | N6 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Mennar of Deeth 28b. Time of 28d. Describe how Injury occurred t Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral E 118 Certifying Phyeicisn: To the best of my knowledge, death occurred et the time, dete end piece, snd due to the ceuse(s) end menner es ststed.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, snd due to the cause(s) end menner steted. Medical 29a. Certifier 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mount 023 my 30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print) Dlen Bornie onathan MO 14066 toman 5. (main 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-0703-510 anne dashields State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Febuary 07,2000 DASHIELDS **Physician** Anne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner 3619 Manchester ave. Baltimore # Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 16 7933 Director Marylow Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location Director BALTIMOVE Mary / tro 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 n 23a or must be MANCHESTER AUG 21215 3619 11512 Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-,12) College (1-4or 5+) Private fomiles 12 to grade DUMETTIC 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be fill timent of Health and Mental Hi tant: If Item 27 is marked oth jury or other traumatic aven Be BENJAMIN SPURGE, SHRAH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 🔑 🖊 🗲 3619 MANCHESTER AUE Boltmur, Ad Mary THORNTON FrIEND 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 21. Signatura of Funaral Sarvice Licensee

22. Name and Address of Facility CIA THE BY HORE STORES WAS Approximate shock, or haart failure. List only on a cause on each line. Department of Important: If It any Injury or o once. **Physician** Immediata Causa (Final disease or condition rasulting In death) /Medical Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): USB BS P.O. 23b. Did tobacco use contribuje to the cause of death?

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Director: Af

within 24 hours To the Funeral D

Part It. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I.

1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Inspection 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA XIO Yas 2 No Other: 4 Nursing Homa IXIX Residence 6 ☐ Other (Specify) 27. Manyar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Avatural 5 Panding invastigation 1 Yes 2 No 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homloida 29a. Cartifiar

29b. Signature

1 Certifying Phyalcian: To tha best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

2 Swedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

FEB 1 1 2000 >

29d. Data signed (Month, Day, Year) 29c. License number

O.C.M.E.

Febuary 07,2000

3. Time of Death

10d. Inside City Limits

Approximate Intarval Between Onset and Death

10768 2 No

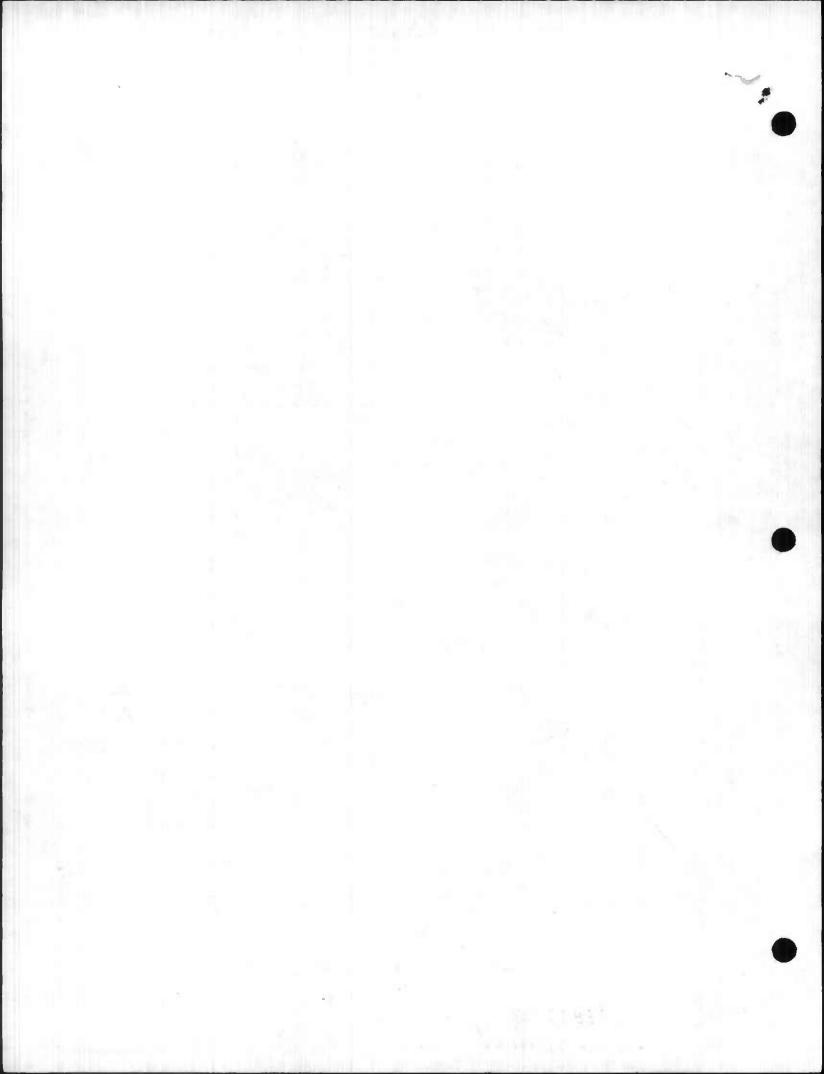
8:08 A.M.

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 2:00 PM FEBRUARY 9, 2000 WALTER DORMAN WILLIAM 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 301 WENDE WAY GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) 180 M 2□ F Months Days Hours 71 Yrs. 225-32-8561 NOV. 13, 1928 VIRGINIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 WENDE WAY 21061 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 K Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1947-1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Specify: 1970 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ MILITARY INTELLIGENCE U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES **EDWARD** DORMAN SALLIE RAMSEY M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. DORIS LUCILLE DORMAN (WIFE) 301 WENDE WAY, GLEN BURNIE, MARYLAND 21061 2/14/2000 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition tX Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervat Between Onset and Death fmmediete Cause (Finet disease or condition resulting in death) arrhythmia munediate Due to (or as a consequence of): 1 Rury Coronary rleru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitaf: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide

Examiner Box 68760 o 0 Records, Division of Vital

Examiner physician and the burial-transit The law requires that the death certificete be executed Physician/Medicai 188 þ Completed paga 2 a Be Certification: To this funaral Aftar or Attending a after on a Director: An 24 hours after Funeral Directions of the Police of the Pol Hospital edicai To the Hosp within 24 hos To the Fune completely fi

Physician

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Physician

/Medical

Baltimore, Maryland 21215-0020

Registrar

DHMH 16 Rev 6/95

State

4 Homicide

(Check only one)

29b. Signeture and title of certifier

Joman

My

28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number 023811

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year)

2 1061

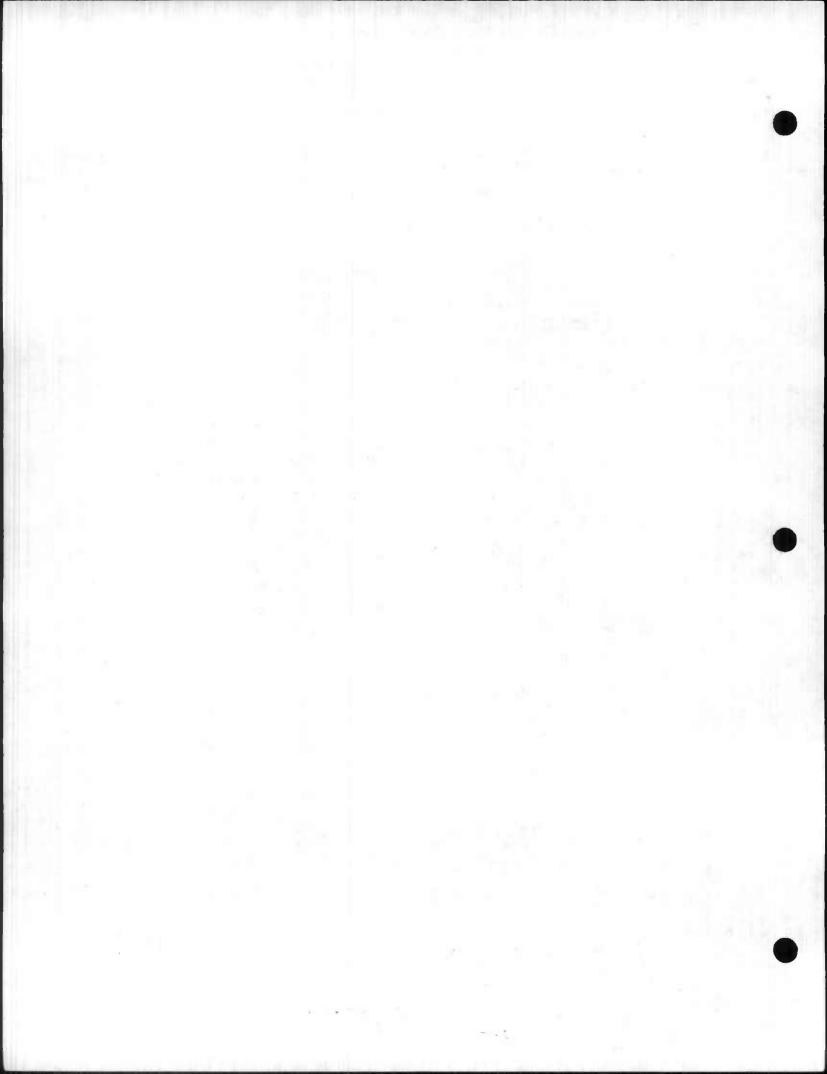
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14068 S. Crain Jonathan forman 31. Date filed (Month, Day, Year)

2000

glan Burnie 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorothy Jean Day February 10, 2000 3:45PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 10 M 20 F Months Days 217-36-2616 64 June 12, 1935 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 East Chatsworth Ave. 21136 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, Whita, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Harry Thomas Kay Naomi S. Lochard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 144 Old Ford Drive, Camp Hill, PA 17011 D. Marie Hass Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) All Saints Cemetery 2/12/00 Reisterstown, MD 22. Name and Address of Fecility 21. Signature of Funeral Service-Licensee 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 LITTLE FUNE A HOME KETS LET

23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth date Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 280 No 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Haspice 1 Yes 25(No 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physicien and the buriei-transit The lew requires that the deeth certificate be executed for use es signed by the e or Attending Physicien: this Affer deeth.

Physician

/Medical

Examiner

Funeral

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Pages 1 and 2 should be nent of Health and Mental

Important: If Nem 27 is any injury or other tra-ance.

Physician /Medical

Examiner

Directo

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Examiner Box 68760 Physician/Medical Records, P.O. þ Completed Division of Vital Be 10 Certification: e Hospital or Attendii n 24 hours effer deeth. e Funerel Director: A sietely filled in by the fo

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only

29b. Signature and #6e of certified

and address of person who on Rile 6-BMC

11

d cause of death (Item 23a) (Type, Print) 6701

29c. License number

Cornying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Indicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

N. Charles St. Bulto. Md 21204

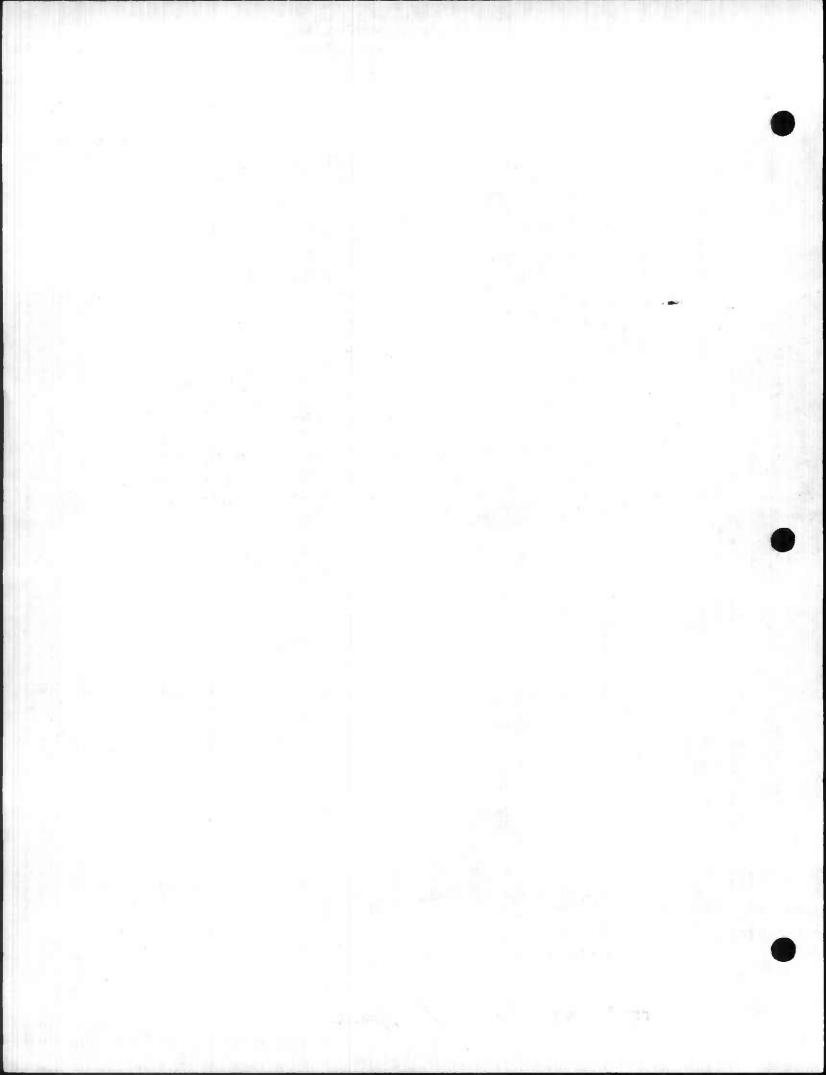
Registrar's Signature

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Donald Davis Jay February 3, 2000 17:10 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Davs XXM 2□ F Months Hours 218-32-6936 62 March 7, 1937 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits VYes 2□ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4302 Falls Road 21211 USA 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Armed Forces:
1 No
If Yes 2 No
If Yes, Give
Yeer or Detes:1954-1962 1 ☐ Never Married 2 X Married 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Security Guard Art Museum 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Jay Donald Davis, Sr. Gladys Kaylor 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey E. Davis Wife 4302 Falls Road Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State Maryland Veterans Cem. 2/8/2000 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) Pa MUHAR A12010 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of degth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

ahow.

ns 23s or 25s-f shormal be notified at

'natural', or llams 23a or

Hygiene.

permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy,
Importants if hear 27 is marked offer

altimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

Directo

Funeral

à

Completed

Be

Examiner Physician/Medical þ Completed Be

physician and s the burial-transit signed by the a d be detached f page 2 s Certification: To

the death certificate be execu And a vice of the state of the edical completely

To the F within 2 State

Registrar

SERNAR Dey, Year) 31. Dete tiled (Month, 2000 FEB

5 Pending investigation

6 Could not be determined

27. Menner of Death

1 Netural

2 Accident

3 Sulcide

29e. Certifier

4 Homicide

(Check only one)

29b. Signature and title of bertifier,

30. Name and address of person who completed cause of death.(Item 23a) (Type, Print).

1 Inpatient 2 ER/Outpatient

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28a. Dete of injury (Month, Day Year)

AV 32. Registrar's Signeture

300 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner steted.

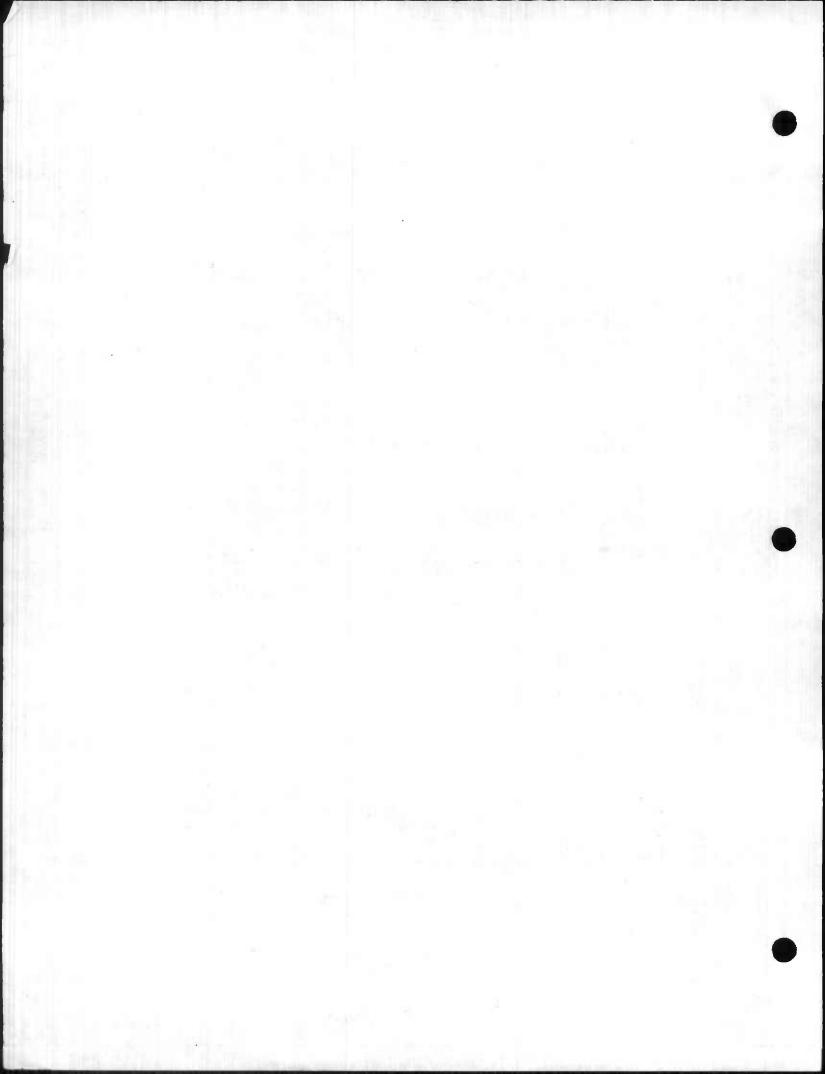
29c. License number

1 Yes 2 No

28d. Describe how injury occurred

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



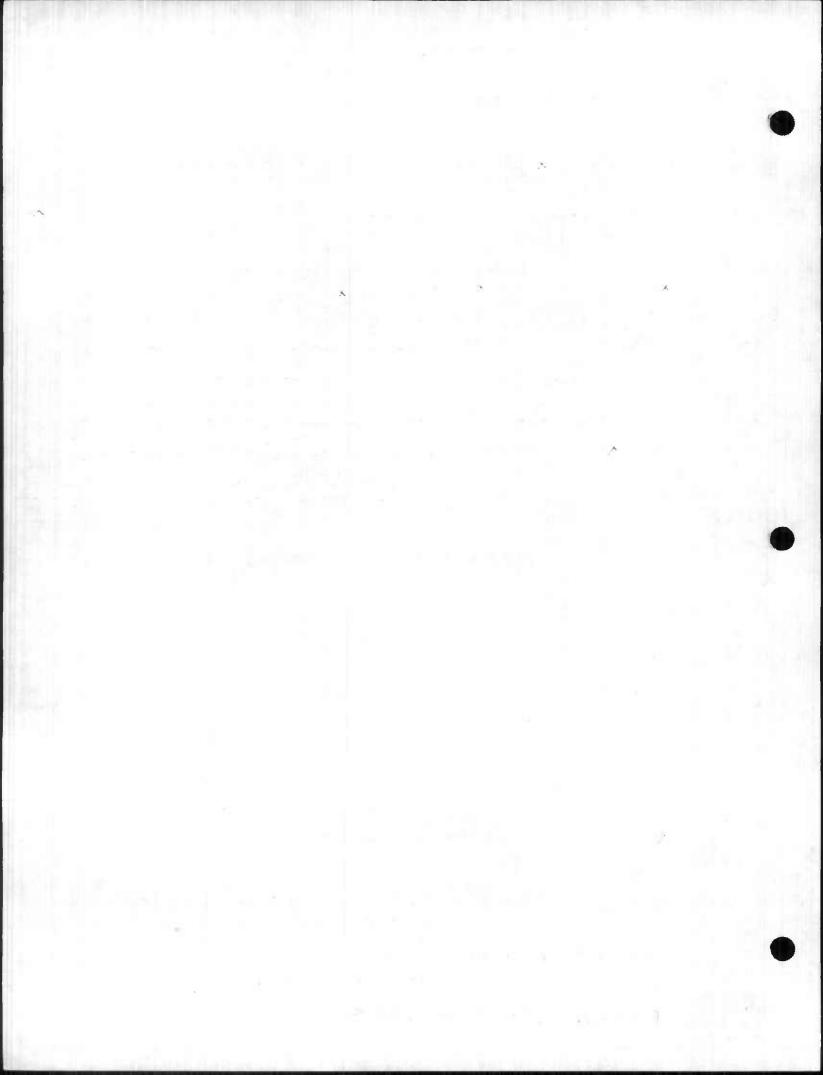
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| | | 8 777 | C | ertificate | e of Dea | th | | leg. No. | UL | 203 | |
|--|---|---|-------------------------|------------------|---------------------------------|-------------|---|--------------------|----------------|--------------------------------|--|
| Dhusisian | 1. Decedent's Name (First, Middle, L | | | | | | 2. Date of Dea Month | th Day | Year | 3. Time of Death | |
| Physician /Medical | a a a se bu mittinge | el Dietz | | | | | | ARY 3, 2 | | 1130 AM | |
| Examiner | 49 Facility Neme (If not institution, g | | | | | | ocation of Death | | | | |
| 94 | 7308 DUNMANWAY | | 4 | H Hodos | 1 Year If Un | NDALK | | | LIMORE | | |
| Funeral Director | 216-52-3834 | Sex 7. Age (In yrs 12 | s. last birthda Yrs. | Months | Days Hou | | 8. Date of Birth (Month, Day 0 7 2 5 | Year) | Country | e (State or Foreign) ID | |
| Pu R | Usual Residence of Decedent 10a. Stete 10b. County | 10c. C | ity, Town or | Location | | | | | 10d | Inside City Limits | |
| Ne Mary | Md Balti | more | Dun | dalk | | | | | | 1 Yes 295No | |
| O siter death with the Mai or terms 23a or 28a-fa rites mast be notified Funeral Director | 10e. Street and Number 7308 Dunmanway | Apt A | | 10f. Zip | 22 | 47 | | USA | | | |
| J. 1 | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No H Yes, Give Yeer or Detes: | U,S. 13 | | ent of Hispanic ify Cuban, Mex | | Specify Yes or No- to Rican, etc.) 14. Race - American Black, White, etc. Specify: Whi | | | | |
| 72 ho | 15. Decedent's E (Specify only highest g | | 16a. Dec | edent's Usual | l Occupation k done during i | most of won | kina | 16b. Kind of B | usiness/Indus | itry | |
| 1 21215-00 led within 72 hot tygiene. The than "naturality for the following Commission" | Elementery/Secondery (0-12) | Coilege (1-4or 5+) | life | . DO NOT us | e retired) | | | | | | |
| Co Present | 12 17. Father's Neme (First, Middle, Las | *1 | Fac | tory | Worker | | ne (First, Middle, | Facto | 4 | | |
| Maryland d 2 should be file th and Mental Hy 7 la marked oth traumatic event | Corned D Diet | • | | | | | e Olga | | 10) | | |
| arylan, should be the marked of umarke eva | 19e. Informent's Neme/Reletionship | | 10b Me | iling Address | | | ral Route Numbe | | State 7in C | nde) | |
| and 2 s selth ar n 27 la | Gerard Dietz, | | | | | | | | | | |
| altimore, mit. Peges 1 ar partment of Hee portant: if Item 2 y Injury or other | 20e. Method of Disposition | 20b. | Plece of Dis | position (Nam | her place) C: | rem. | Baltim Date | 20c. Location - | | | |
| Peges nent of I | 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Spec | Theurover from State | | | shing | | 02 09 | Laure | l. Md | | |
| Balti Pemit. Departm Importa- any Injui | 21. Signeture of Funeral Service Lice | ** | | 22. Neme end | Address of F | acility | | | | | |
| D SEES | Tales & Cooper | Dapla | | | | | latthew ng Roa | | | ome, Ind. 2122 | |
| Physician /Medical Examiner | Immediate Ceuse (Finel disease or condition resulting in deeth) | · Atheroscl Due to | | equence of): | diova | scular | n Disa | ease | | nset and Death | |
| The cords, P.C. Box 68760, The law requires that the death certificate be executed at the been signed by the attending physician and page 2 should be detached for use as the burlal-transit completed by Physician/Medical Examiner | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due to | or es a cons | equence of): | | | | | 1 | | |
| BOX 58/50, neth certificate be exattending physician for use as the burial | | | | | | | | | | | |
| d for all | Pert ff. Other algorificant conditions | contributing to death but not re | sulting in the | underlying ca | use aiven in P | Part I | 23b. Did tobecco use contribute to the cause o | | | | |
| IS, P.O. BOX es that the death ce igned by the attendit be detached for use by Physician/ | Alloh | | Source III | andonying oz | 300 g. 601 117 1 | GIV 1. | | | | bly 4 Unknown | |
| HECOLGS, The law requires the spe 2 should be done of the specific the speci | | | | | | | 24a. Was a | an autopsy med? | availe | autopsy findings | |
| The law requirements to pege 2 should Completed | | | | | | | Limit | ed | of de | eletion of cause eth? | |
| af eleg | | | | | | | 1,00°Y | es 2 No | 12(| res 2□ No | |
| N VICAL HE hysiclen: The la his certificate her il director, page 2 | 25. Wes case referred to medical exeminer? | | | | | lace of Dea | th (Check only o | ne) | | | |
| | No 2□ No | | ER/Outpat | | | Nursing H | ome XX Resid | | | | |
| Ing P. Affer Junear Junear Jon: | 27. Menner of Death 1 Netural 5 Pending | 28e. Dete of Injury (Month, Dey Year) | 28b. Time Injury | | Bc. Injury at Work? | O CINO | 28d. Describe h | ow injury occur | red | | |
| DIVISION C be or Attending P is after death. In Director: After it led in by the funera Certification: | 2 Accident Investigetion 3 Suicide 6 Could not | De Diose of Injury At I | hama farm | M I | 1 Yes | 2 [] NO | 28f. Location (S | Troot and Numb | ner or Rural S | loute Number | |
| Direct A in by the state of the | 4 Homicide determined | building, etc. (Spec | ify) | stroot, rectory, | Onico | 7. | City or Tow | | | | |
| To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | | hyatclan: To the best of my kn miner: On the basis of examin and menner steted. | | | | | | | | | |
| ithin ithe outher of the outher of the outher of the outher outhe | 29b. Signeture and title of certifier | end morning stolet. | | 29c. | License numt | ber | | 29d. Date signe | d (Month, Da | y, Year) | |
| F 3 F 8 | 1 + 11 | 111. | 1- | | O.C.M | | | | ARY 4, | | |
| 00 | 30. Name end address of person who | completed cause of death (in | m south | MD | | | | | | | |
| | ^ | | | | t, Balt | imore | , Maryla | and 2120 |)1 | | |
| State | 31. Dete filed (Month, Day, Year) | 32. Registrer's Sign | | 1 | | | | | | | |
| Registrar | TENE 1 1 2000 | Deneros 1 | 9. 4 | oak | / | | | | | | |

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04204 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. 4 2000 11:45AM FRANCIS D. DILWORTH, JR. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6104 Everall Avenue Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 6. Date of Birth Month, Day, Year, April 26, 1950 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Hours 1€M 2□ F Months 49 Baltimore, Maryland 219 52 7022 Yrs Usual Residence of Deceden 10b. County 10c. City, Town or Location t0d. Inside City Limits 1 Yas 2 No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 6104 Everall Avenue USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Accountant Accounting Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis D Dilworth Sr Irene A Kessler 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Y Weaver (Sister) 5405 Elsrode Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park February 8,2000 | Baltimore, Maryland 22, Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Licensee 7401 Belair Rd. Baltimore, Maryland 21236 ations that caused the leath. Do not a cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Be

Funeral

Director

ahoa!

herrs 23a or 28a-f

natural, or

Hygiene.

permit. Pages 1 and 2 should be fits.
Department of Health and Mantai Hy important: if New 27 is marked other any injury or other tree.

altimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

4

Alber Athending

Hospital or Attend 24 hours after death Funeral Director:

To the Hospital within 24 hours a To the Funeral Completely filled

Examine

Physician/Medical þ Completed Be 2 Certification:

edical

29s. Certifier

29b. Sin

25. Was case referred to medical examigar 1 ☐ Yes 2 ☐ No 27. Manger of Death 1 ENatural

2 Accident 3 Suicide 4 D Homicide

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year)

28b. Time of

28c. Injury st Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number lapa Man h.D.

D0013649 of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed Month, Day, Year)

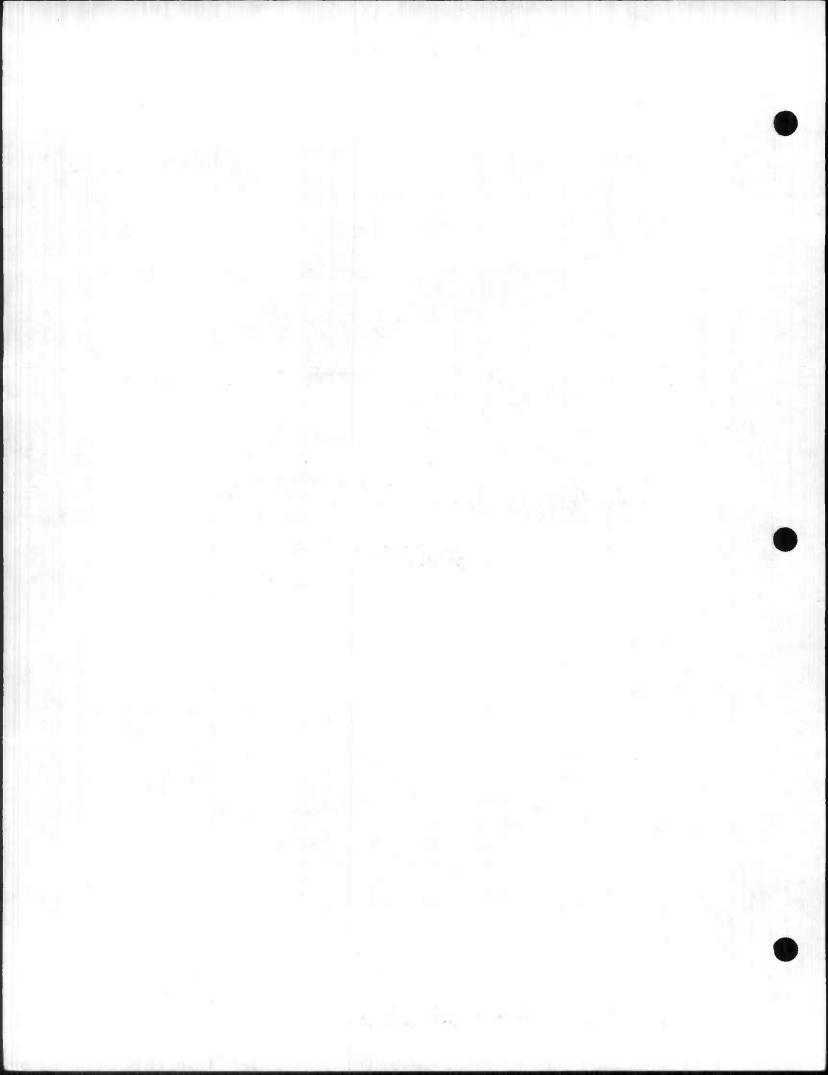
NESTOR 31. Date filed (Month, Day, Year)

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M. D. 6012 HARFORD ROAD BALTO, Ad extry

State Registrar

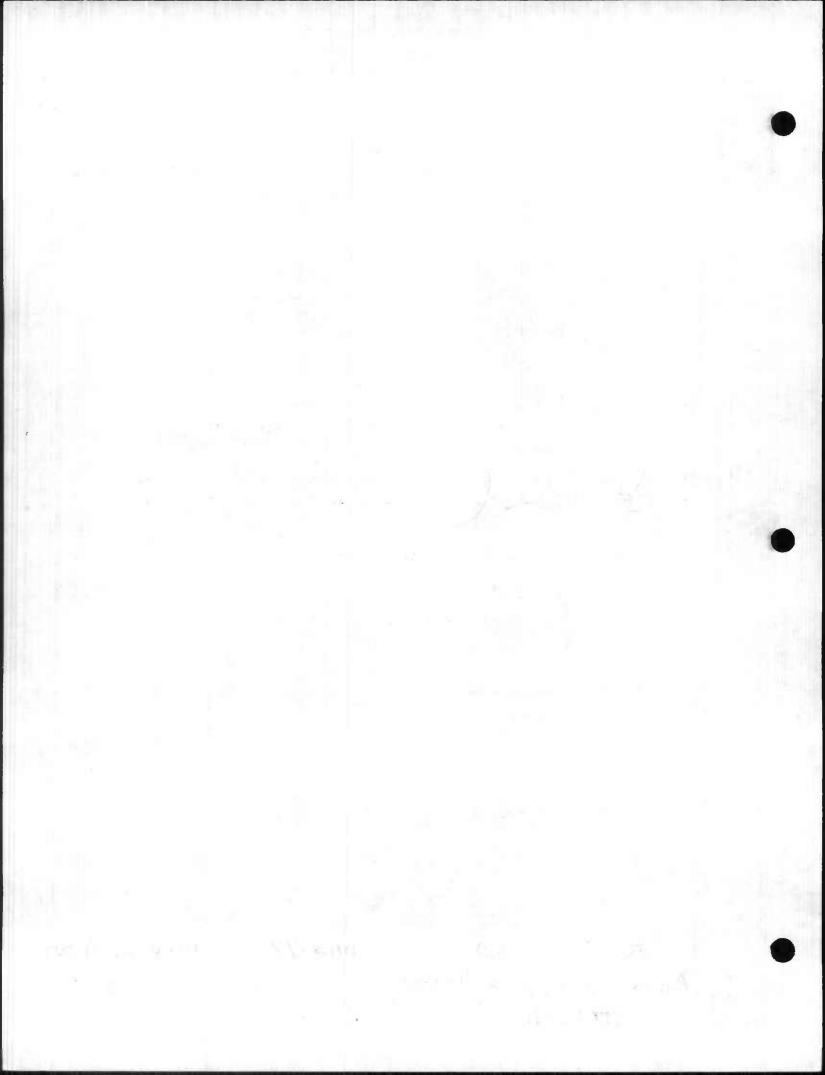
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| | | State of I | Maryland / Dep Ce | partment of the partificate of | | | | giene | 0 0 | 14205 | |
|--|---|--|---|---|-----------------------------|-----------------------------|--|--|-----------------------|--|--|
| Physician | Decedent's Name (First, Middle Irene Elizabe | | | | | | Data of Dea Month bruary | Day | Year | 3. Time of Death 7:43 PM | |
| /Medical Examiner | 4a Facility Nama (If not institution | | | | 4b. City, To | wn, or Locat | | 4c. County | | 7.45 111 | |
| Zammer | North Arundel | Hospital | | | Glen | Burni | е | Anne | Arun | del | |
| Funeral Director | 5. Social Security Number 224-14-3468 | 6. Sex 7. | Age (In yrs. last birthda) 77 Yrs. | Months Days | If Under Hours | Min. | Date of Birth (Month, Dey UIV 22 | Year) | Count | ace (Stete or Foreign in) | |
| 2 | Usual Rasidence of Decedent | | T | | | | | • | | | |
| anylas ehov | 10a. State 10b. County | | 10c. City, Town or | Location | | | | | 10 | Od. Inside City Limits 1 ☐ Yes ※☐ No | |
| Peerlo | | ne Arundel | Gl | en Burnie | | | | | | | |
| with with | 10e. Street and Number 1011 Roseanne 1 | 2024 | | 10f. Zip Code | 1000 | | | log. Citizen of \ | | | |
| ne 23 | 11. Marital Status | 12. Was Decede | nt Ever in U.S. 13 | | 1060 | inin? (Specif | Yas or No- | | ted St | | |
| of ZTZ 15-0020 Ified within 72 hours efter death with the Maryland Myglene. They than "natural", or theme 23s or 28e-1 ehow mit, the Maryland Emmirer must be notified at a Completed by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Force | No | Was Decedent of I If Yes, specify Cub | | | an, etc.) | | ck, White, e | etc. | |
| 1 Z1Z15-0 ed within 72 ho ygiene. Ar than natura ft. tra fide at Completed | 15. Decedent (Specify only highes | 's Education | 16a. Dec | 16a. Decedent's Usual Occupation (Give kind of work done during most of working | | | | | | ustry | |
| In least of the le | Elamentary/Secondary (0-12) | College (1-4c | life. | DO NOT use retire | t or working | | | | | | |
| and 212. be filed within that Hygiene. d other than event, the Be Comp | 8 | | | Bus Compa | _ | | | Transp | | cion | |
| E sees a | 17. Father's Nama (First, Middle, I Walter T. Owe | | | | 18. Motha | | | <i>Maid</i> en <i>Sumen</i> .rginia | | atroot | |
| Maryland 2 should be file th and Mental Hy 7 is merked othe treumatic event | | | 10h Ma | lina Address (Otron | and Mumb | | | | | | |
| end 2 s end 2 s eeith an n 27 le i | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town 19c. Informant's Name/Relationship (Type, Print) | | | | | | | | | L006) | |
| 0 | 20a. Method of Disposition | Daughter | | oosition (Neme of emetory or other pla | | | | 20c. Location - | | wn, State | |
| altimore, mit. Pages 1 er partment of Hee portent: If Hem 2 f Injury or other | 1 X Buijal 2 Cremation 4 Denation 5 Other (Sp | | | emetory or other pla en Mem. Pl | | 200 | | | | Maryland | |
| Baltimore, N permit. Pages 1 and Department of Heelth Important: If item 27 eny injury or other it page. | 21. Signature of Funday Service L | | | | | | | | | naryrana | |
| D 90 mpo | 1 A 201. | and | | 22. Name and Addre Kirkley-Ri 421 Crain | Hwy. | S.E. | Glen E | Burnie, | | 1061 | |
| Physician | 23a. Part1. Enter the disaase, or shock, or heart failure. List of | complications that caus only one cause on aach | et the death. Do not e | ntar tha mode ot dyi | ng, such as | cardiac or re | espiratory arr | rest, | | Approximate Interval Between Onsat and Death | |
| /Medical Examiner | Immediata Cause (Final disease or condition rasulting in death) Acute Respiratory Failure | | | | | | | | | 2 Days | |
| | Dua to (or as a consequence ot): | | | | | | | | ľ | | |
| secuted in end isi-transit | | Bacte | rial Pneumo | | | | | | 110 | Days | |
| 60, / be exacuted sician end burial-transit | Sequantially list conditions, if any, teading to immediate | Chron | Dua to (or as a cons | | Dices | | İ | Years | | | |
| 8750, sete be exemply shysician ethe burial- the burial- | | | | | | | | | 1 | lears | |
| P.C. BOX 68/60, et the death certifices be executed tby the attending physician end etached for use as the burial-transit Physician/Medical Examis | resulting in death) Last | d | J. | | | | | | | | |
| Cla dfor | Part II. Other elgoiffcent condition | | 22h Did to | - hanna | mtelbude to | the name of death? | | | | | |
| 5 th 5 | Part II. Other arginizatit condition | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | the causs of death? | |
| es thet igned be dete | Atrial Fibri | llation | | | | | | 'ss 2☑ No | 001100 | abiy 4 dolikilowii | |
| requir been s should | | | | | | | 24a. Was a perfor | an autopsy med? | ava | ra autopsy findings iliabla prior to npletion ot causa leath? | |
| The level page 2 | | | | | | | 1 🗆 Y | es ŽŽ No | 10 | Yes 2□ No | |
| certificate rector, pa | 25. Was case referred to medical | | | | 26. Place | of Death (C | | | | 100 1010 | |
| Phyalcien: this certific | examiner? 1 ☐ Yas 2, ☐xNo | Hospital: | itient 2 ER/Outpati | ent 3 DOA Oth | 200 | | | ence 6 Oth | ar (Specify |) | |
| Attending Ph r deeth. ector: Atter th by the tuners! | 27. Manner of Death 1x3Natural 5 Panding 2 Accidant investign | | njury 28b. Time Day Year) Injury | Wo | | 280 | | ow injury occur | | | |
| 2 2 2 2 2 | 3 Suicide 6 Could n 4 Homicide datarmii | ned 288. Place of | tnjury - At homa, farm, s etc. (Specify) | treet, tactory, office | | 281. | Location (S City or Tow | treet and Numb n, Stete) | oer or Rura | Route Number, | |
| Hospi 24 hou Funer tely fill | 29a. Cartifier XX Certifying (Check only one) 2 Medical E | Physician: To the best xaminer: On the basis and mannar | st of my knowledge, dea of examination and/or i stated. | th occurred at the timestigation, in my convertigation, in my convertigation. | me, data an opinion, daa | d place, and th occurred | due to tha cat the time, d | ause(s) and ma late and placa, | anner as stand due to | ated. the cause(s) | |
| within 2 To the comple | 29b. Signature and the of certifiar | 175 177 | F-177 | 29c. Licens | se number | | 2 | 9d. Data signe | d (Month, L | Day, Year) | |
| 25 | 30. Name and addrass of person w | mat the completed saves | I death (Item 23a) (Type | D4 | 397 | 7 | 1 | isma | my | 9 2000 | |
| 87 | Aypten Die 31. Data tiled (Month, Day, Year) | inn · 30 | 1 Hoster | Arve. | Gler | By. | me | .mo | 12/2 | 61. | |
| State Registrar | FEB 1 | 2000 | Deperal / | 9 page | RS | | | | | | |

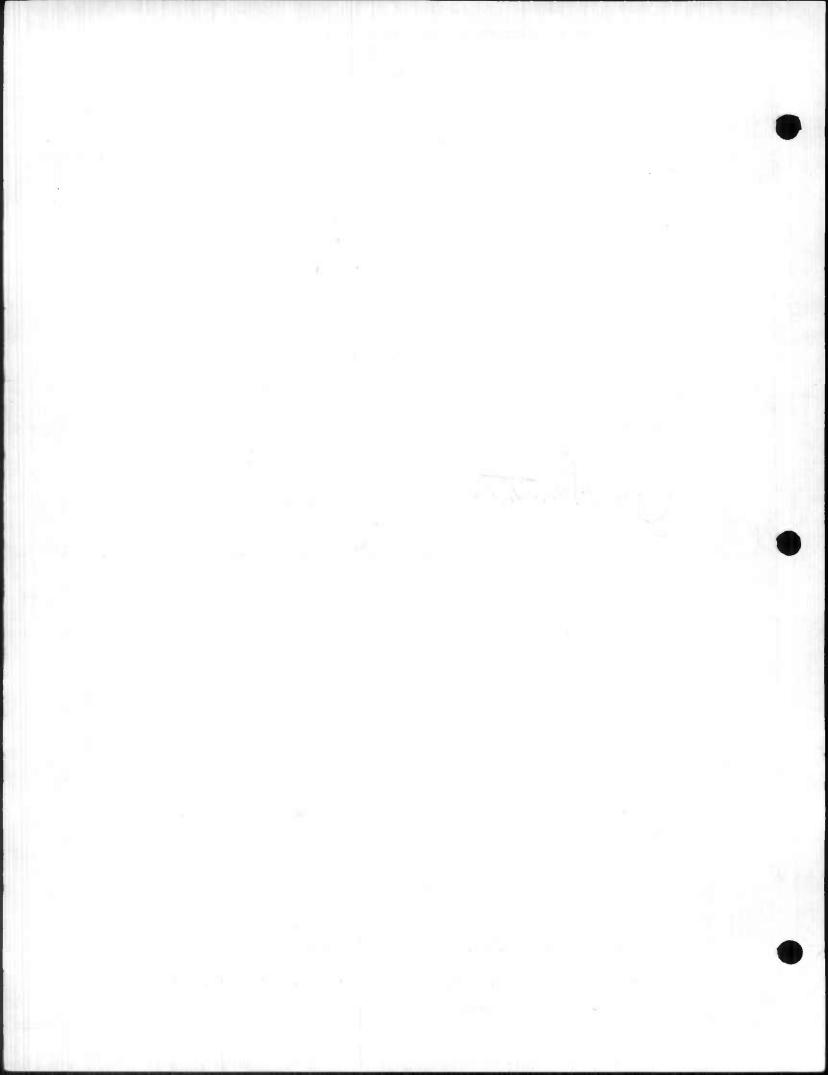
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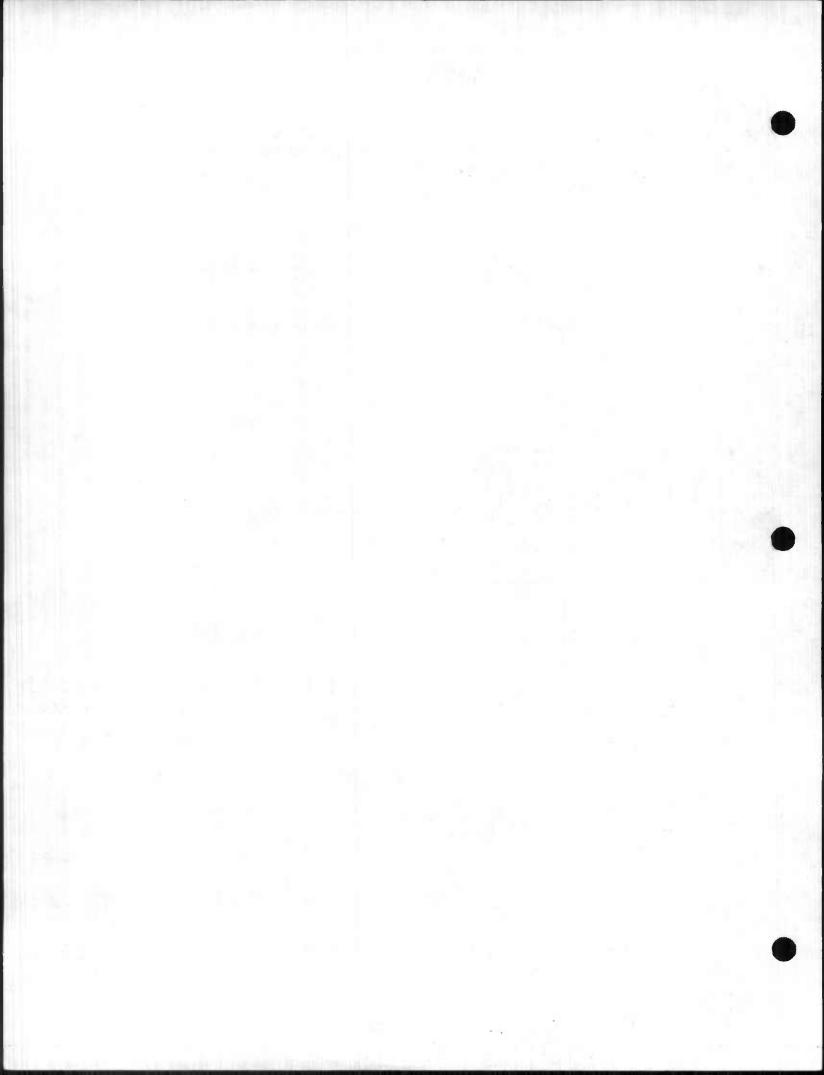
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State of Maryland / Department of Health and Mental Hygiene 1 1 1 2 1 6

| | | 1 Decedente Name (First Add) | o èl | | (| Certifica | ate of | Death | | Reg. No. | | 4200 | |
|--|------------------|--|--|--|-----------------------------|--|----------------------|--|--|---|---|---|--|
| Physicia | an | Decedent's Neme (First, Middle, La | | | | | | | 2. Dete of De Month | Dey | Yeer | 3. Tima of Deeth | |
| /Medic | | | Emerson | | | | | | Januar | - | | 12.10 | |
| Examine | er | 4a. Facility Neme (If not institution, giv | A Company of the same | | | | | 4b. City, Town, or | | | | | |
| | | Fairland Adventi | | _ | | | | Silver S | | | tgomer | 3 | |
| Funeral Director | | 5. Social Security Number 6. S 577-34-9280 Usuel Residence of Decedent | ax 7. Ag ☐ M 2⊠ F | ge (In yrs. 86 | lest birth | Month | lar 1 Yaar s Deys | If Undar 24 Hrs. Hours Min. | 8. Date of Bir (Month, De Nov. C | th by, Year) 12,1913 | 9. Birthp Coun Minn | elece (Stete or Forai etry) esota | |
| r 28a-f show | | 10a. Stete 10b. County | | 10c. C | ity, Town | or Location | | 1 | 0d. Inside City Limi | | | | |
| I a | cto | Maryland Montgom | ery | Sil | lver | Spring | 5 | | | | | 1 ☐ Yes 2 ☑ N | |
| ms 23a or 28a-f show | Funeral Director | 10e. Street and Number 2101 Fairland Roa | d | | | | 2ip Code | | | United Am | Citizen of What Country? of America | | |
| al', or items Examiner in | þ | 11. Maritel Stetus 1 ☐ Navar Merrlad 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | J,S. | 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify: | | | pecify Yas or No o Rican, etc.) | Spec | ace - Americ ack, White, ify: Whi | etc. | |
| 2 should be filed within 72 ho and Mental hygiene. Is marked other than "natur aumatic event, the Medical | ted | 15. Decedent's Ed | lucation | | 16e. Decede | ecedent's Us | sual Occup | ation | | 16b. Kind of | | | |
| | пре | (Specify only highast gra Elementary/Secondary (0-12) | College (1-4or | 5+) | 9 | life. DO NOT use retire | | · | | | | | |
| | 3 | 12 | 4 | | | HOME 1 | MAKER | | | OWN | | | |
| | Be | 17. Fethar's Name (First, Middle, Last, | | | | | | 18. Mother's Nar | ne (First, Middle | , Maiden Sume | den Sumeme) | | |
| | 2 | UNKNOWN | | | | | | UNKNOWN | | | | | |
| | | 19e. Informent's Neme/Reletionship (| | and Number or Au | | | | | | | | | |
| Health tarn 27 other tr | | Jim Emerson/ So | n | 3288 Pikkard Dr. | | | | | | | | | |
| Department of Health importent: If Item 27 any injury or other tr | | 20e. Method of Disposition 1 Burial 2X Cremetion 4 Donetion 5 Other (Specific | | | | Disposition (A cremetory of .ncoln | | | ry Dete FEB.11, 2000 Brentwood, Maryland | | | | |
| Depart Import any in | | 21. Signature of Funeral Service Coor | Wach/ | | | | | | | | | Home, Inding, MD 20 | |
| nysician Medical kaminer | ler | Immediate Ceuse (Final diseasa or condition resulting in death) | ө/ | 100 | | DIAC nsequence of | | FARCTI | on | | | ACUTE | |
| g physician and as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting In deeth) Lest | b. — Due to (or es e consequence of): C. — Due to (or es a consequenca of): | | | | | | | | | | |
| | | L | d | | | | | | | | | | |
| od for | sicia | Pert il. Other significant conditions o | ontributing to death b | ibuting to death but not resulting in the underlying cause | | | | | 23b. Did | Did tobacco use contribute to the cause of deat | | | |
| | by Physician/I | • | | | - | | | 1 Yes 2 No | | | | | |
| | Completed b | | | | | | | | 24e. Wes | en eutopsy ormed? | ava | ere eutopsy findings allable prior to mpletion of causa deeth? | |
| page ; | 5 | | | | | | | | 1 🗆 | Yes 2 DNO | 10 | Yes 20 No | |
| certificate rector, pag | Be | 25. Wes case referred to medical examinar? | | | | | | 26. Place of Dea | ath (Check only | one) | | | |
| a di | ၉ | 1 Yes 2 No 27. Manner of Deeth 1 Panaturel 5 Pending | Hospital: 1 ☐ Inpetion 28e. Dete of Inju (Month, Da | | ER/Outp 28b. Tin Inju | ne of | 28c. Injui Wo | y et k? | lome 5 Resi | | | y) | |
| within 24 hours after death. To the Funeral Director: After this certific complataty filled in by the funeral director, | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | | ury - At h c. (Speci | ome, fam fy) | M , street, fect | | Yes 2□No | 28f. Location (Street and Number or Rural Route Number City or Town, Stete) | | | I Route Number, | |
| 24 hours Funeral ataly fille | edicai | 29a. Certifier (Check only one) 1 Certifying Ph. 2 Medicat Exam | ysictan: To the best hiner: On the besis o | examina | owledge, o | leath occurre or investigation | d at the tir | ne, date and place pinion, death occu | , and due to the irred et the time, | cause(s) end r date end place | nanner es st | tated. the cause(s) | |
| o the | 100 | end menner stated. | | | | | | a number | Т | 29d. Date sign | ed (Month | Dey, Year) | |
| 3 F 8 | | · hundle | in my |) | | | 1 | 24997 | | | 2/20 | | |
| , , | 1 | OO blome and address of account | amalatad assess | looth (Itor | - 02-\ /T. | D 1 4) | | | | | | | |
| | | 30. Name and address of person who can be Luis Casas, M. | | | rry l | | Laure | 1,Maryla | nd 207 | 07-4830 | | | |



| | | | | | | e of | Doam | | | Reg. No. | | 1 has | UI |
|--|---|--|--|---|---------------------------------|--|---|----------|--|---|--|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day | | | | | | | | | | Year | | e of Death | |
| cian dical | DANIEL J. ETH | - | | | | | | | FEBRUA | RY 10, | 2000 | 8: | 15aa |
| ninër | 4a Facility Neme (If not Institution, VA MARYLAND HE | | FORT | HOW | cation of Deal | th 4c. Count | ty of Death | | | | | | |
| al or | 5. Sociel Security Number 2A2 22 1459 Usual Residence of Decedent | 6. Sex 1 ☑ M 2 ☐ F | 7. Age (In yrs. le | est birthday) Yrs. | If Under Months | 1 Year Days | If Under: Hours | Min. | 8. Date of Bi (Month, Di 07-22 | rth ay, Year) 2-25 | 9. Birth Cou | place (Sta intry) NC | te or Forei |
| | 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | - | | | | 10d. Insid | e City Limi |
| jo | MO N | lA | Bar | TIMOR | - | | | | | | | | res 2 n |
| Director | 10e. Street and Number | | One | 41117010 | 10f. Zip | Code | | | 10g. Citizen of What Country? | | | | |
| | 504 POPULAR G | PROVE ST | DEET | | 2 | 127 | 2 | | | | 1190 | | |
| Funeral | 11. Maritel Stetus | | dent Ever in U,S | 3. 13. \ | Ves Deced | ent of Hispanic Origin? (Specify Yes of y Cuban, Mexican, Puerto Rican, etc. | | | | or No- 14. Race - American Ind | | | 1, |
| þ | 1 Never Married 2 Marrie 3 Widowed 4 Divorced | ed 1 2 Yes If Yes, Giv | 1 Yes 2 No If Yes, Give Year or Dates: | | | | Specify: | , rueno | rican, etc./ | Specify: BLACK | | | |
| Completed | 15. Decedent' (Specify only highest | s Education | | 16a. Deced | kind of worl | k done | dunna most | of work | na | 16b. Kind of E | | | |
| du | Elementary/Secondary (0-12) | Coilege (1 | Coilege (1-4or 5+) | | | e retired | 1) | | | POST | ACC. | 50.0- | |
| | 12 TH GRADE 17. Father's Neme (First, Middle, L | 1 41 | 2 | MA | 11 | MIN | DLER | do Nome | /Cinch Middle | | | | |
| Be | 17. Father's Neme (First, Micole, L | ast/ WK | | | | | | | me (First, Middle, Maiden Surname) SEYMORE | | | | |
| 10 | 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu | | | | | | | | | | Ctoto 7 | in Code) | |
| | KEVIN ETHERIDG | | U | 4812 1 | | | | | ALTIMO | | - | 21207 | , |
| | 20a. Method of Disposition | IL CON | 20b. Pla | ace of Dispo | sition (Nam | e of | | | Date | 20c. Location | | | |
| | 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp | ecity) | stete | Metery, cren UNSVILL | E VA | CE | METER | - | 15.00 | CROWNS | | , M | 0 |
| | 21. Signature of Funeral Service L | icensee | | VA | UGHN | C. | SS OF FACILITY GREE | NE | FUNERI | AL SERV | ICE 21229 | | |
| | 23a. Pert1. Enter the disease, or o shock, or heart failure. List of | complications that ca | used the death. | | | | | | | | 1 | Approxi | mate Between |
| | | | | | | | | | | | | | nd Death |
| | Immediate Cause (Final disease or condition | GASTR |) INTES | LINAL . | ADI NO | CAI | CLIP | IA | | | | - 200 | 100 |
| | resulting In death) | w | | as a conseq | uence of): | | | | | | 1 | | - |
| Examiner | | b. UNKNO | N PRIM | ARY | | | | | | | i | | |
| xar | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or | as a conseq | uenca of): | | | | | | | | |
| | Cause (Disease or injury that initiated events | c | Dura to for | | | | | | | | 1 | | |
| edical | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | |
| 3 | resulting in death) Last | d. | | | | | | | | | | | |
| sician/M | resulting in death) Last Part II. Other eignificant condition | d. | ath but not resul | iting in the ur | nderlying ca | use giv | en in Part i. | | 23b. Did | tobacco uae c | ontribute | to the cau | se of deat |
| Physician/ | | | | iting in the ur | nderlying ca | use giv | en In Part i. | | | tobacco use co | | | |
| by Physician/ | Part II. Other eignificant condition | CARCINOI | D | iting in the ur | ndertying ca | use giv | en In Part i. | | 1 🗆 | | 3 Pro | obably | Sy findings |
| by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG | CARCINOI | D | iting in the ur | nderlying ca | use giv | en In Part i. | | 1 24a. Was | Yes 2□ No s an autopsy | 3 Pro | Vere autop vailable prompletion | sy findings for to of cause |
| Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LAING POST PANCREATIC | CARCINOI | D | iting in the ur | derlying ca | use giv | | | 1 24a. Was | Yes 2 No s an autopsy ormed? Yes 2 No | 3 Pro | Vere autop vailable pr ompletion f death? | sy findings for to of cause |
| Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC | CARCINOI CARCINOI | D D | ting in the ur | | Oth | 26. Place | of Death | 24a. Was peri | Yes 2 No s an autopsy ormed? Yes 2 No | 3 Pro | Vere autopovailable prompletion f death? | sy findings for to of cause |
| To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investigs | CARCINOI CARCINOI Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | patient 2 E | | t 3 DO | A Oth | 26. Place ef: 4 □ Nu | of Death | 24a. Was period (Check only me 5 🗆 Res | Yes 2 No s an autopsy ormed? Yes 2 No one) | 3 Pro 24b. V a c o 1 | Vere autopovailable prompletion f death? | sy finding for to of cause |
| To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Panding | CARCINOI CARCINOI Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | patient 2 E | R/Outpation 28b. Time of Injury ne, farm, str | t 3 DO/ | Oth | 26. Place er: 4□ Nur y at k? | of Death | 24a. Was performe 5 Res 28d. Describe | Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 00 | 3 Production of the Control of the C | Vere autopy valiable prompletion if death? | sy finding for to of cause |
| Certification: To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investige investige investige determined. 3 Suicide 6 Could not determined. | CARCINOI CARCINOI Hospital: 1 Drawn ation 28a. Date o (Month buildin physician: To the baxeminer: On the baxeminer: On the baxeminer: On the baxeminer: | patient 2 E I Injury b, Day Year) of Injury - At hom g, etc. (Specify) | R/Outpatien 28b. Time of Injury ne, farm, stre | t 3 DO/ | Oth Co. Injury Wor Coffice | 26. Place er: 4 □ Nu y at k? Yes 2 □ It | of Death | 24a. Was perful. 1 | Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Othor injury occur (Street and Num wn, State) | 3 Pro 24b. V a c c o 1 ther (Speciarred | Vere autop vailable prompletion of death? Yes ihy) | sy finding for to of cause 2 No |
| To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investigate Panding | CARCINOI CARCINOI Hospital: 1 | patient 2 E I Injury b, Day Year) of Injury - At hom g, etc. (Specify) | R/Outpatien 28b. Time of Injury ne, farm, stre | t 3 DO/ | Oth Worlds Injury Office | 26. Place er: 4 □ Nu y at k? Yes 2 □ It | of Death | 24a. Was perful. 1 | Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Othor injury occur (Street and Num wn, State) | 3 Production of | Vere autop vailable prompletion of death? Yes ify) stated. to the cause | Sylvanber, |
| edical Certification: To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investige investige 6 Could not determined. 29 Accident 6 Could not determined. | CARCINOI CARCINOI Hospital: 1 Drawn ation ation ation be led 28e. Placa building Phyelclan: To the base and mann and mann are a control of the base and mann are co | patient 2 E I Injury b, Day Year) of Injury - At hom g, etc. (Specify) | R/Outpatien 28b. Time of Injury ne, farm, stre | t 3 DO/ | A Other North Confidence of the time in my of Licens | 26. Place er: 4 Nu y at k? Yes 2 1 | of Death | 24a. Was perful. 1 | Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Othow injury occu (Street and Num wn, State) cause(s) and m date and placa | 3 Production of | Vere autoposition of death? Yes ify) ral Route if stated. to the cau- | Sylvanber, |
| Medical Certification: To Be Completed by Physician/ | Part II. Other eignificant condition HISTORY OF LUNG POST PANCREATIC 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investige investige 6 Could not determined. 29 Accident 6 Could not determined. | CARCINOI CARCINOI Hospital: 1 Drawnation 28a. Date o (Month ation 28e. Placa a buildin Phyelcfan: To the ba and mann G. C. CUSTODIO | patient 2 El Injury of Day Year) of Injury - At homog, etc. (Specify) post of my know sis of examination stated. | ER/Outpatien 28b. Time of Injury ne, farm, stre dedge, death on and/or inv | M 28 M 28 M 28 M 29et, factory, | Oth Worlds Injury Office | 26. Place er: 4 Nu y at k? Yes 2 1 | of Death | 24a. Was perful. 1 | Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Othor how injury occur (Street and Num wm, State) cause(s) and m date and placa | 3 Production of | Vere autop vailable prompletion of death? Yes ify) stated. to the cause | Sylvanber, |

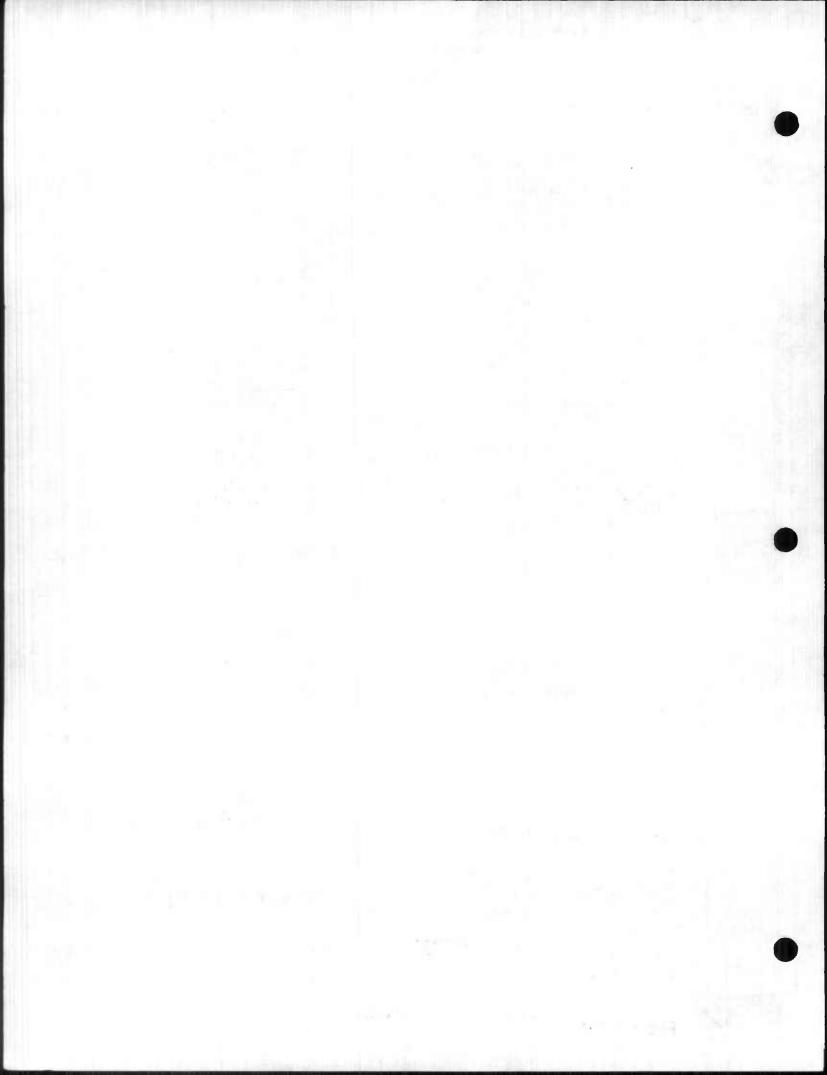


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Ω Ω Ω Ω

| | Decedent's Name (First, M. | Riddle foot | | Cert | ificate c | f Death | 2. Dete of De | Reg. No. | | | | |
|--|---|--|--------------------------------------|---------------------------|--|---|--|---|--|--|--|--|
| Physician | | | | | | | Month | Dey | Yeer 3. Time of Death | | | |
| /Medical | Gertrude El | | | | | T 41 On T- | Feb. | 10, 200 | | | | |
| Examiner | 4a Facility Name (If not instit | | er) | | | | or Location of Deat | | | | | |
| WI | 18 Windy Hil | | | | | Glen Arm | | Baltin | | | | |
| Funeral Director | 5. Social Security Number 218–14–0557 Usual Residence of Deceden | 1□ M 21√F | Age (In yrs. last b | Yrs. | Months De | | Ain. 8. Dete of Bi (Month, Di July 25 | | | | | |
| pue k | 10a. State 10b. Con | | 10c. City, Tov | vn or Loca | ation | | | | t0d. Inside City Limits | | | |
| Meny cto | MD Balt | timore | Glen | Arm | | | | | 1 ☐ Yes 2 ☐XNo | | | |
| or 28 | 10e. Street and Number | 1 | | | 10f. Zip Cod | Ð | | 10g. Citizen of W | | | | |
| Baitimore, Maryland 21215-0020 permit. Peges 1 and 2 should be tiled within 72 hours effer deeth with the Meryland Department of Heelth and Mentel Hygiene. Important: if health and Mentel Hygiene. Important: if hear 27 is marked other than "natural", or home 23a or 28a-1 show any highly or other treumatic event, the Medical Example most be notified an ansa. To Be Completed by Funeral Director | 18 Windy Hill I | | | 45.101 | 21057 | | | United S | | | | |
| | 11. Marital Status 1 Never Married 2 1 3 Widowed 4 Divor | Married 1 Yes 2 | 1 T Yes 2 D No | | | of Hispanic Origin? uban, Mexican, Pu lo Specify: | ? (Specify Yes or No uerto Rican, etc.) | | e - American Indien, k, White, etc. : White | | | |
| | 15. Dece | dent's Education ghest grade completed) | 16a | Deceder | nt's Usual Oc | cupation | working | 16b. Kind of Bu | siness/Industry | | | |
| od within 72 hor vyglene. The free meturn it, the free completed | Elementary/Secondary (0-1 | T | or 5+) F | lorist | | ne during most of ired) | WOIKING | Floral | | | | |
| D BEER OO | 17. Father's Name (First, Mid | de (ast) | | | | 18 Mother's I | Name (First, Middle | Maiden Sumam | a) | | | |
| Maryland d 2 should be file d 2 should be file th end Mentel Hy T is marked othe treumatic event. | Leonard Matusk | | | | | | trude Rhea | , | | | | |
| , Maryle and 2 should all her marks or treumetic or treumetic To | 19a. Informant's Name/Relat | | | | | | Rural Route Numb | | Stete, Zip Code) | | | |
| mazz her z | Susan Rowe / D | andinar | | | ndy Hill | | Arm, MD 21 | | | | | |
| Baltimore, semit. Peges 1 e popertiment of Heam moortants if Nem my Injury or othe side. | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe | on 3 Removel from Sta r (Specify) | te Chesap | ery, creme exeake (| tion (Neme of story or other) Cremator | y, Inc | 2-12-00 | Beltsvil | City or Town, State | | | |
| Balt permit. Depart import eny inji | 21. Signature of Euneral Serv | rice Licensee | | CAI | Name and Ad FA Steph | en D. Long | mann, P.A. Dr., Towson | MD 21286 | | | | |
| | 23a. Parti. Enter the disease shock, or heart failure. | o, or complications that caus | sed the death. Do | not enter | the mode of | tving, such as care | diac or respiretory | irrest. | Approximate | | | |
| Obvolsion | shock, or heart failure. | List only one cause on eecl | h line. | | | | | | Interval Between Onset and Death | | | |
| Physician /Medical | Immediate Cause (Final | | Subara | 1 | . 1 1 | 1 | 10 - 1 - | | 11 1000 | | | |
| Examiner | disease or condition resulting in death) | 9 0045 | | | | | | | | | | |
| | | | Due to (or as s | conseque | ence of): | | Q | | | | | |
| 68760, fices be executed physician and a the buriel-transit edical Examiner | Samuentially list conditions | | | | | | | | | | | |
| 60, be exected or clan or burnel-t | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | Due to (or es a | | | | | | | | | |
| | that initiated events resulting in death) Last | | Due to (or as a consequenca of): | | | | | | | | | |
| desth cardesth card for use | | d | | | | | | | | | | |
| yalci | Part II. Other algnificant con- | ditions contributing to death | but not resulting | in the und | erlying ceuse | given in Pert I. | 23b. Did | Did tobacco uss contributs to the cause of de | | | | |
| P set y | COPD | | | | | | 10 | Yss 2 No | 3 Probably 4 Unknown | | | |
| d be de | | | | | | | | | | | | |
| Popularion should | | | | | | | | s an autopsy ormed? | 24b. Were sutopsy findings available prior to completion of cause of death? | | | |
| The lew page 2 | | | | | | | 10 | Yes 20/No | 1 Yes 2 No | | | |
| Vital I | 25. Was case referred to med | fical | | | | 26 Place of I | Death (Check only | | | | | |
| Of Vita Physician: this certific ral director, | examiner? | Hoenital: | atient 2 ER/O | . du adiant | a□ D04 | Oak | g Home 5 Res | | (0%) | | | |
| Pyd star | 27. Manner of Death | | | Time of | 3LI DON | 4 LI NUISIN | | how injury occurr | | | | |
| Afre ton | 1 Natural 5 Per | 28a. Date of li (Month, li estigation | Day Year) | Injury | | njury et Vork? ☐ Yes 2 ☐ No | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | |
| Division of the north of the second of the s | 3 Suicide 6 □ Co | uld not be 28e, Place of | Injury - At home, for etc. (Specify) | arm, stree | | | | (Street end Numb | er or Rural Route Number, | | | |
| D o de l'india | 200 Contilion | | | | | | | | | | | |
| Division To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the Iunes Medical Certification | 29a. Certifier Check only 2 Mediane) | fying Physician: To the be cal Examiner: On the basis and manner | of examination or | e, death o nd/or inves | stigetion, in m | time, date and pli y opinion, deeth o | ace, and due to the occurred at the time, | cause(s) end ma , dete end place, a | nner as stated. and due to the cause(s) | | | |
| To the comple | 29b. Signature and title of cer | tifier /// | | | 29c. Lice | ense number | | 29d. Date signed | (Month, Day, Year) | | | |
| , 1 | Allan | BULL | W MI | 2 | D | 3494 | / | 2-11 | -00 | | | |
| 7 | 30 Alame and address of pers | soft who completed cause of | death (Hom 23a) | (Type, Pr | le M | 1 / 2 | 1234 | | | | | |
| State | 31. Date filed (Month, Day, Ye | sar) 32. Regi | strar's Signature | 1 | - // | 9 01 | 1 | | | | | |
| Registrar | FED 1 1 2000 | Seren | p. , | Spa | KS | 1 | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 04209 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Henry J. Freund February 10,2000 5:00AM 4a Facility Name (If not Institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death 1307 Turret Road Harford Be1 Air If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 2 □ F Yes 65 216-30-0506 March 8,1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 1307 Turret Road 21014 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No
If Yes, Give 1952-1956
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Engineer Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Palermo Henry J. Freund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna May Freund/ Wife 1307 Turret Road Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc.2/11/2000 Beltsville, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. Laura C. Hardesty 8717 Green Pastures Drive Baltimore, MD 21286 23a. Part1. Enter the disease, or complications Ital caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Pancreatic Cancer. Immediate Ceuse (Finel 5 months disease or condition resulting in death) Due to (or as a consequenca of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

signed to Attending Physician: this Affer To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by completely

Physician

/Medical

Examiner

Directo

Funeral

Completed

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Funeral

Director

a or 28e-f

238

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hours after

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Pages 1 and 2 should be ment of Health and Menta ant. If them 27 is marked lury or other traumatic as

Department of Important: If any Injury or

Physician

/Medical

Examiner

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Examiner

Physician/Medical

Completed by

Be

Certification: To

edicai

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

Registrar

31. Date filed (Month, Day, Year) FEB 1 1 2000

29b. Signature and title of certifier

Jikevin LYNCH 32, Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2 North Ave. Bel Air, Md. 21014 oakst

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

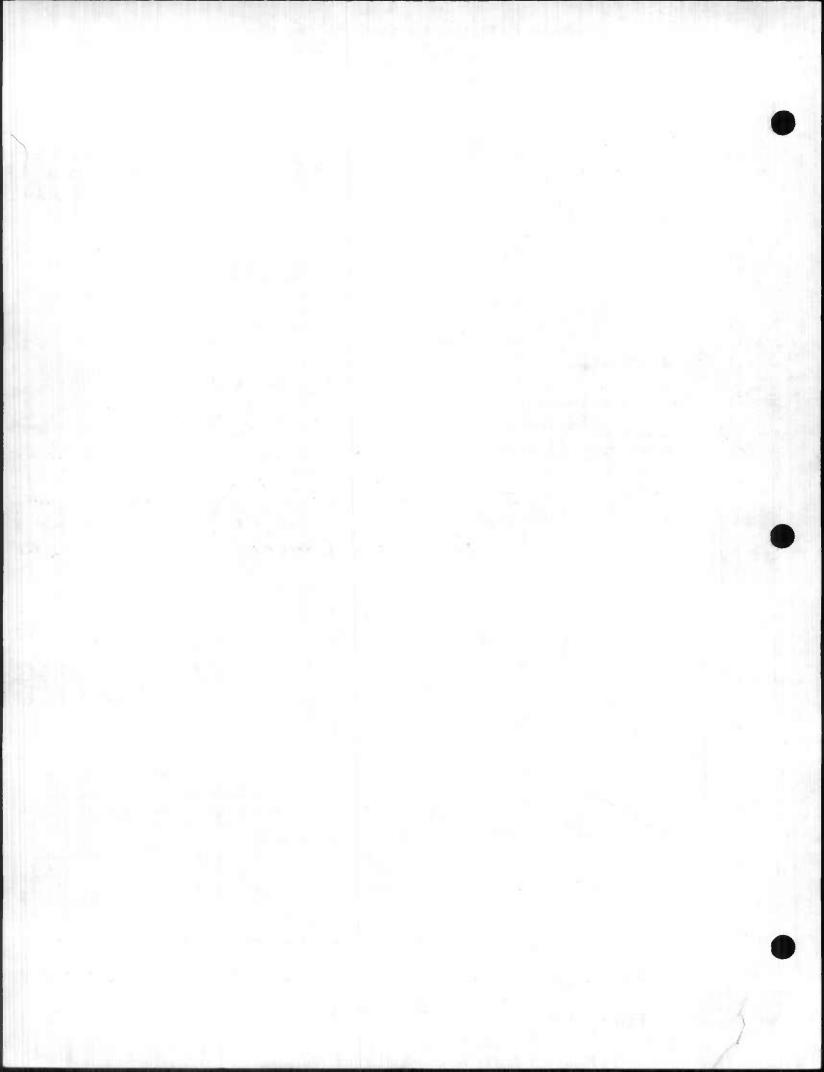
29c. License number

D35012

29d. Date signed (Month, Day, Year)

February 10,2000

MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Certificate of Death

Reg. No.

2. Dete of Death

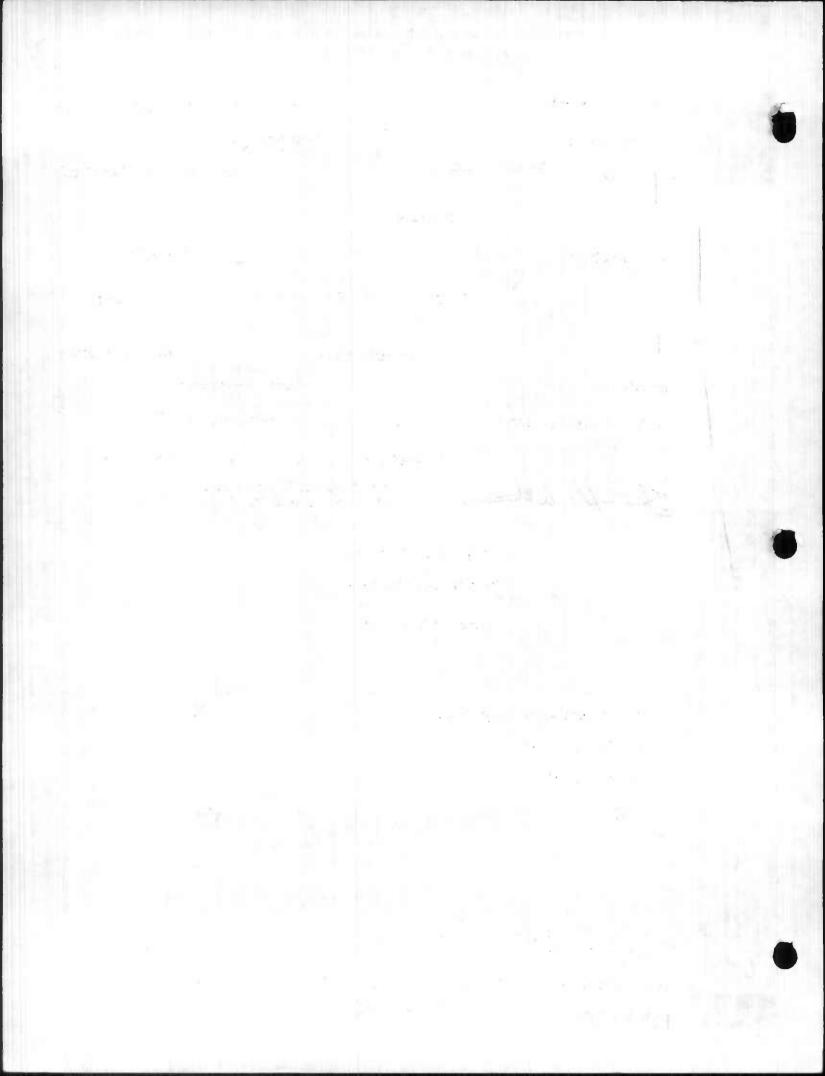
Month

Name (First, Middle, Last)

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| Usua 10a. | Residence of | Decedent 10b, Count | | | 10c. City, To | num or Loop | tion | | | | 1 | 0d. Inside City Limits | |
| | 7. | 100. Count | у | | Baltir | | tion | | | | | 1X Yes 2 □ No | |
| 2 | Street and Nur | mber | | | Leuch | IDLC | 10f. Zip Code | | | 10g. Citizen of What Country | | | |
| 5 0 | 22 Fawr | | | | | | 21202 | | United States | | | , | |
| | laritel Status | 1 Sulect | 12. Was I | Decedent E | Ever in U,S. | 13. Wa | | Hispanic Origin? (S an, Mexican, Puer | pecify Yes or N | | e - Americ | rican Indian, | |
| | ☐ Never Merri | | rried 1 XY | d Forces? res 2 □ No., Give or Dates: | w II | 1 C | Specify | Black, White, etc. ecity: White | | | | | |
| | | 15. Decede | nt's Education | | 16 | Sa. Deceder | nt's Usual Occup | pation | | 16b. Kind of Br | | | |
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| p 17. Fa | 17. Father's Name (First, Middle, Last) | | | | | | | | | e, Maiden Suman | ne) Maria | | |
| 0 3 | dn Fer | | | | | | | Maria | Maccer | Ma | | ntelli | |
| | 19a. Informant's Name/Reletionship (Type, Print) Gloria Hartley / Daughter 19b. Malling Addr 2822 N. | | | | | | | | timore, N | | State, Zip | Code) | |
| - | Method of Disp | | / nanginer | - 1 | 20b. Place | of Disposit | ion (Name of | Ī | Dete | 20c. Location - | City or To | own. State | |
| 1 | Burial 2 | Cremation | 3 □Removal fi | rom State | ceme | Commercity, Crematory or other place) Thesapeake Crematory, Inc. 2-11-00 Beltsville, MD | | | | | | | |
| | Donation Signature of Fu | | | | UES | - | lame and Addre | , , , , , , , | 2-11-00 | DELLOVII | ic, iii | | |
| 1 | 1 | - 1/ | . O. At | | | CAI | TA Stephe | n D. Lohame | | MD 24200 | | | |
| 23a. | Part1, Enter ti | he diseese. o | or complications to | nat caused | the death. D | | | Pastures Dr ing, such as cardia | | | b | Approximate Interval Between | |
| | shock, or hea | rt failure. Lis | st only one cause | on each lin | 10. | | | | | | 1 | fnterval Between Onset and Death | |
| | | | Immediate Cause (Final disease or condition Acute Myocardial Infarction | | | | | | | | | | |
| disease or condition resulting in death) ACTUE MYCCARCHAIL ITELAICCLICE a. Due to (or as a consequence of): | | | | | | | | | | | | | |
| | ting in death) | | a | | Due to (or as | e conseque | ence of): | | | | | | |
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| | ting in death) | | a | Corona | Due to (or as | e conseque | ence of): lusion | | | | 1 | | |
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State Registrar Joseph D. Notarangelo
31. Date filed (Month, Day, Year)
FEB 1.1 2000

52. Registrer's Signature sports



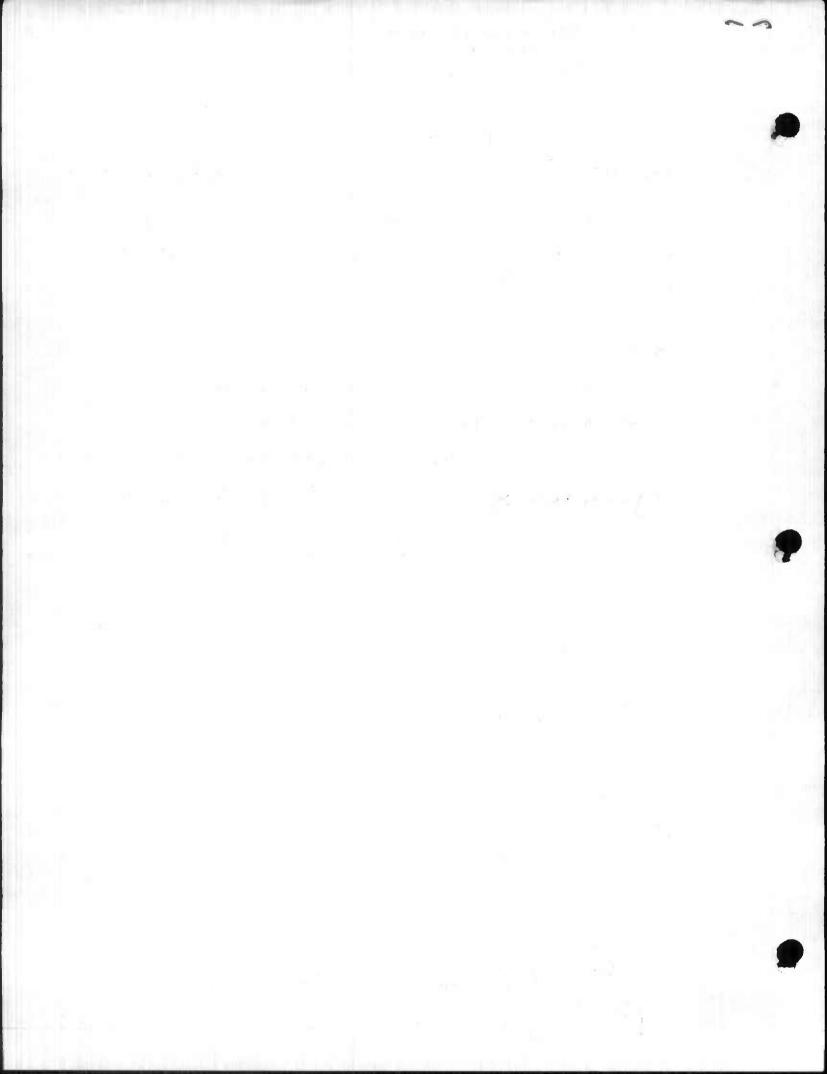
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 04211

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| | Dharata | | 1. Decedent's Name (First, Middle, La | nst) | | | | | | 2. Dete of Dea | ath Dey | Yeer | 3. Time of Death | |
| | Physic /Medi | | Joseph Fav | a | | | | | | Februa | ry 6, 20 | 000 | 11:20 A.N | |
| | Exami | | 4e. Fecility Neme (If not institution, git | ve street end number |) | | | 4b | City, Town, or | Location of Deeth | 4c. County | of Deeth | | |
| | | | Genesis Eldercar | e - Randa | llstow | n | | | Randal1 | stown | Bal | Ltimo | re | |
| | Funeral Director | | 5. Sociel Security Number 6. S 215-12-8007 Usuel Residence of Dacedent | YOU -OF | ge (In yrs. les 32 | Yrs. | If Under 1 Months | Yeer Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Bird (Month, De July 1 | y, Year) 7, 1917 | 9. Birthp Cour Mar | olece (Stete or Foreign ntry) yland | |
| | land m | | 10a. Stete 10b. County | | 10c. City, | Town or Loc | cation | | | | | 1 | IOd. Insida City Limits | |
| | the Mary 28a-f sh offilied | ector | Maryland Baltim | ore | Wo | odlaw | | | | | | | 1 □ Yes 2 No | |
| | 23a or 2 | Funeral Director | 6437 Kriel Stree | t | | | 10f. Zip C | 207 | | | 10g. Citizen of Whet Country? United States | | | |
| 020 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. If Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Expressive must be notified at | by | 11. Maritel Stetus 12 Never Merrled 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces: 1 Yes 2 If Yes, Give Yeer or Detes: | 3 2√∑ No Give 1 ☐ Yes 2√∑ No Speci | | | | | pecify Yes or No o Rican, etc.) | Specify | ce - American Indien, ck, White, etc. | | |
| 5-0 | 72 h | ted | 15. Decadent's E (Specify only highest gr | ducetion | | 16a. Deced | ent's Usuel | Occupat | ion | rkina | 16b. Kind of Bu | isiness/în | dustry | |
| 21215-0020 | filed within Hygiene. Ither than " | Completed | Elementary/Secondary (0-12) 7th Grade | College (1-4or -0- | 5+) | Bake | | retired) | iring most of wor | Amy | Marvla | nd Bi | scuit Co. | |
| P | other if | BeC | 17. Fether's Nema (First, Middle, Last |) | | | | 1 | 18. Mothar's Nar | ne (First, Middle, | | _ | | |
| Maryland | should be nd Mental marked o | ToB | Dominico Fava | | | | | | Rosaria | Guerc | io | | | |
| ary | and & | - | 19e. Informent's Neme/Relationship (| Type, Print) | | 19b. Mailin | g Addrass (| Street er | nd Number or Ru | ral Route Number | er, City or Town, | Stete, Zip | Coda) | |
| | 1 end 2 Heelth a em 27 le | | Mrs. Johanna Dri | frs. Johanna Driver - Sister 6441 Kriel Street; Woodlawn, Maryland | | | | | | | | | 207 | |
| Baltimore, | permit. Pages 1 en Department of Heel Important: If Item 2 any Injury or other once. | | 20e. Method of Disposition 1 | | cen | netery, crem | sition (Neme | er plece, | | Date / O / O O O | 20c. Location - | | | |
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| 68760, | by Realine that the death certificate be executed as the contract of the steer state of the steer state of the steer state of the steer state of the | dicai Examiner | Immediate Ceuse (Finel disease or condition rasulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in daath) Last | b | Due to (or e | es a conseques e conseque | uence of): uenca of): | sen | nentia | | | | Unlines | |
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| | e deal the att hed fo | sici | Pert ti. Other eignificant conditions of | ontributing to death t | out not resulti | ing In the un | derlying cau | ısa giver | n in Pert I. | 23b. Dld 1 | obacco use contribute to the cause of death? | | | |
| P.0 | that the de ed by the deteched | by Phy | 1 types 4 | ensión | | | | | | 10 | Yee 2□ No | 3 Prof | bebly 4 Dinknow | |
| Vital Records, | 単 世の | Completed b | | | | | | | | 24e. Wes perfo | en autopsy med? | ev | ara autopsy findings reilable prior to empletion of cause deeth? | |
| Œ | 9 - 6 | ШО | | | | | | | | 101 | res 2 No | 1[| ☐Yes 2☐No | |
| ŧ | | Be | 25. Wes case raferred to medical | | | | | - | 26. Pieca of Dec | eth (Check only o | ne) | | | |
| 2 | | 2 | examiner? | Hospitel: 1 Inpati | ent 2 EF | NOutpatient | 3□ DOA | Other | 4 Nursing H | loma 5 Resid | dence 6 Oth | er (Specif | 'y) | |
| on of | Ahan funa | | 27. Menper of Deeth 1. Neturel 5 Pending 2 Accidant investigatio | 28a. Date of Inju (Month, De | by Year) 2 | 8b. Time of Injury | 28d | c. Injury e Work? 1 ☐ Ye | et es 2 🗆 No | 28d. Dascribe I | now injury occur | red | | |
| Division | 8 등 등 5 | Certification: | 3 Sulcide 6 Could not be determined | | 28f. Location (S City or Tov | | er or Rure | el Route Number, | | | | | | |
| | To the Hospital of within 24 hours at To the Funeral Discompletely filled in | edicai (| | | | | | | | | causa(s) and ma data end pleca, | nnar as s end due to | tatad. o the cause(s) | |
| | To the comple | Me | 29b. Signeture end title of pertifier 29c. License number | | | | | | | | 29d. Dete signe | | | |
| | .\\/ | |) ///0 11xt | ily |) | | | 7)7 | 7516 | | 7.1 | c/ in |) | |
| 4 | MA | | 30. Nama and address of person who | omplated causa of | death (Itam 2 | 3e) (Type, F | Print) | 21 | 200 | Thee | 11 | #2 | 2.2 | |
| 1 | C | | | 32 Aprilet | n Un rer's Signetur | ra / | 1150 | 5 (| sieme | Ince | 100 | - 30 | N) | |
| | Sta Registr | | 31. Dete filed (Month, Day, Year) FEB 1 1 200 | O Dene | المالا | D | span | KS | • | | | | | |

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death FOWBLE 6:00 PM TOSHUA EGBRUARL 2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DULANEY TOWSON HEALTH CARE CENTER TOWSON BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) 2/4/04 Birthplece (State or Foreign Country) Months 1X M 2□ F 219-30-7564 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes XXNo LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 115 W. SEMINARY AVENUE 21093 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10TH GRADÉ HORSE HANDLER FARM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) JOSHUA B. FOWBLE, SR. MARY MAUDE PARKS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LUTHERVILLE, MD 115 W. SEMINARY AVENUE 21093 BETTIE HUNT NIECE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burlet 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 2/11/2000 COCKEYSVILLE, MD 21. Signeture of Funerel Service Liga 22. Name end Address of Fecility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediete Cause (Finel diseese or condition resulting in deeth) DEHY DRAMON PNEWON'A Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown HEARS BLOCK DEM CONTIA. 24b. Were autopsy tindings 24e. Wes en autopsy performed? available prior to completion of cause of death? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: *Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menper of Death 28b. Time of fnjury 28c. Injury at Work? 26d. Describe how injury occurred 1 Natural
2 Accident 5 Panding investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner Box 68760. P.O. Division of Vital Records, Attending Physician: 5

burial-transit Physician/Medical the for use this funaral death. within 24 hours after deat To the Funeral Director:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

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Completed

Certification: To Be

edical

29e. Certifier

(Check only one)

29b. Signature and title of Cartifier

Funeral

Director

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Pages 1 and 2 should be nent of Health and Mental

nt of Health a : If hem 27 is r or other trai

Physician

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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State Registrar

completely

31. Date tiled (Month, Dey, Year)



M.D.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

7445 FURNACE BRANCH Rd GLENBURNETH21060

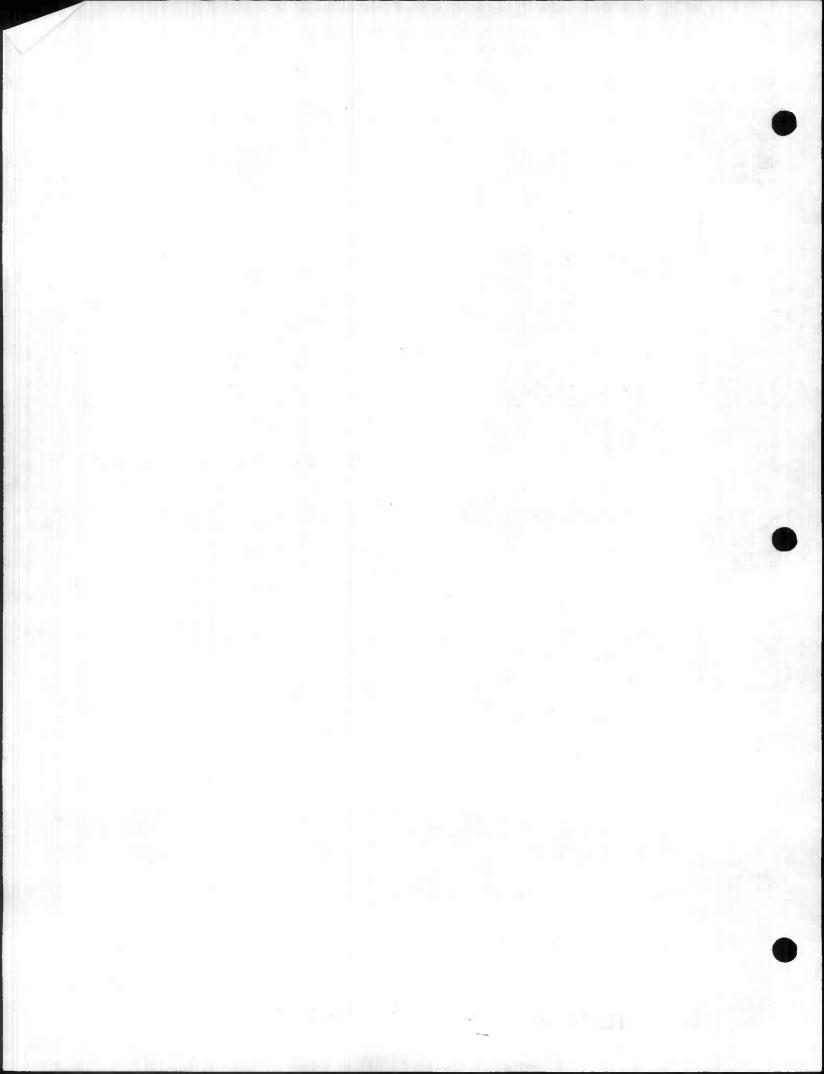
15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner stated.

29c. License number

D. 22609

29d. Date signed (Month, Day, Year)

FG3RVANY 9-2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20b,20c perFHG780 2/15/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month **Physician** MONY February 9, 2000 2127 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Sinai Hospital of Baltimore Baltimore City Baltimore City If Under 1 Year If Under 24 Hrs. | Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dele of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months M 2DF Yrs. Director unknown 0 0 18 0 January 2000 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahon NA Yes 2 No ALTimore Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 2121 USA 4000 -ourl Rema : 11. Merital Status 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 1 Never Merried 2 Merried "natural", or icon 1□ Yes 2 No Specify by 21215-002 3 ☐ Widowed 4 ☐ Divorced Year or Dates: genericon Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked NA 0 NA altimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Pages 1 and 2 should be I nent of Health and Mental I int: If Item 27 Is marked or Michael 19a. Informant's Neme/Relationship (Type, Print) Mother 19b. Meiling Address (Street and Nurliber or Rural Route Number, City or Town, State, Zip Code) Teguila L 20a. Method of Disposition Oswego Court BOYO BATTIMOS, MD. 4000 21215 20b. Place of Disposition (Name of cemetery, cremetory or other) 20c. Location - City or Town, State Balto, Md Donation 5 Other (Specify) Department of Important: If eny injury or page. Love Park February H, 1000 21. Signature of Funerel Service Licensee 638 N. Gilmor Steel 22. Name and Address of Facility BAD mu, MD. 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart leiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Causa (Final disease or condition resulting in death) /Medicat Fungal sepsis 6 days Examiner Due to (or as a consequence of) Extreme prematurity 18 days The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es a consequence ol): US0 28 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea Milo 3 Probably 4 Unknown Records, ð 3 24b. Were eutopsy lindings aveilable prior to completion of cause of deeth? Completed pege 2 should 24a. Wes en autopsy performed? No No certificate 1 Yes Division of Vital or Attending Physician: funeral director. 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 2 Accident 5 Pending death. 1 Yes 2 No investigetion after death e d 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only 29b. Signature and albe of pertitle 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

31. Date liled (Mooth, Day, Year) FEB 1 2000

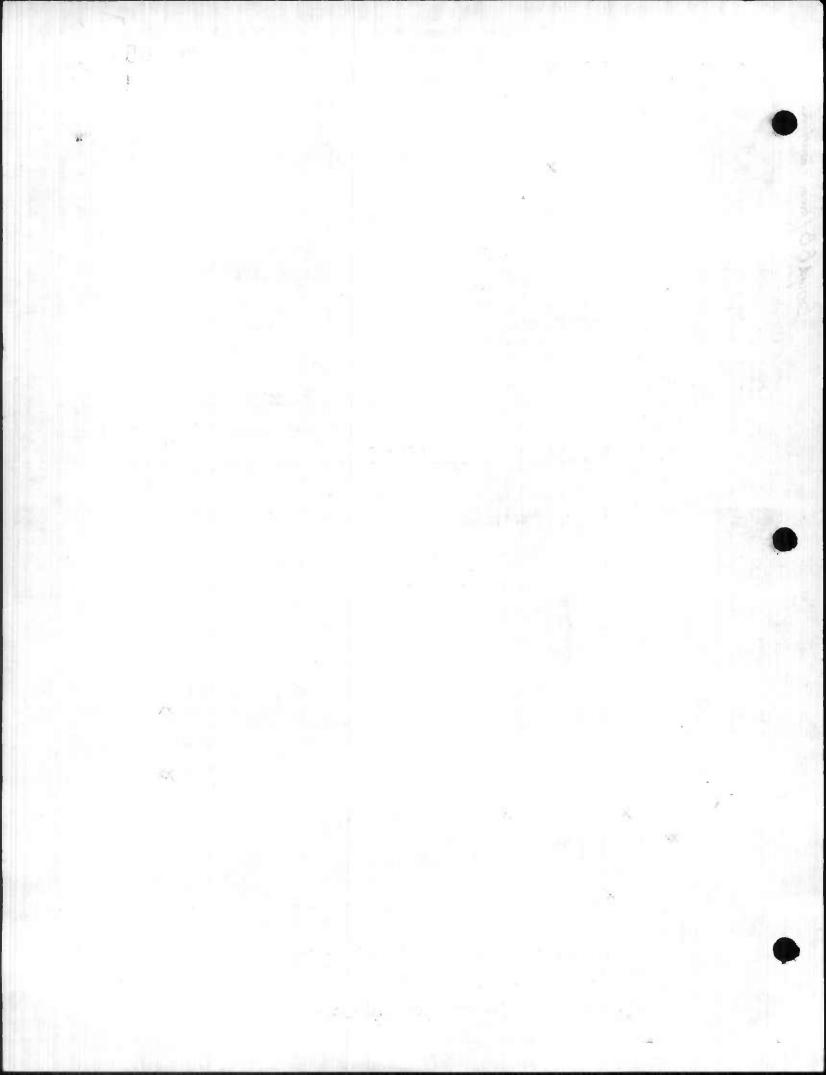
Catherine Partyka, M.D. Sinai Hospital 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Ave. Baltimore Md 21215

D-52144

February 9, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Decedent's Name (First, Middle, Last) 3 Time th 66 Month FEBRUARY 4, 2000 05:30 A.M. 4b. City, Town, or Location of Deeth give street and number) 105pita Social Security Number 18-58-317 If Under 24 Hrs 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year 9. Birthplace (State or Foreign Compty) 102 M 2□ F Days Yrs. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 152 Yes 2 □ No 10g. Citizen of What Country? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Mantal Status 1 Never Married 2 Married 1□ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during mo
life. DO NOT use retired)

ONSTRUCTION WOY 15. Decedent's Education 16b. Kind of Business/Industry during most of working (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Fether's Neme (First, Middle, Last) John 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 20b. Place of Disposition (Name of commetery, crematory or other place, 4 Donetion 5 DO er (Specify) 21. Signeture of Funeral Service Licent 2122 ase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final Hemorrhag disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yee 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? 25. Was case referred to medical 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

ò items 23a

the

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

"natural", or

permit. Peges 1 and 2 should be filed within Depentment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetic.

the buriel-tren

The law requires that the deeth certificate be executed attending physician for use es the burie ed by the signed by t peen s page 2 s After this certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

Examiner Physician/Medical Completed by Be

Medical Certification: To

29a, Certifier 29b. Signature and title of certifier

examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homiclde

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending

investigation

6 Could not be determined

hysician

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D2182

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Yeer)

Baltimore 21229

Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Michae

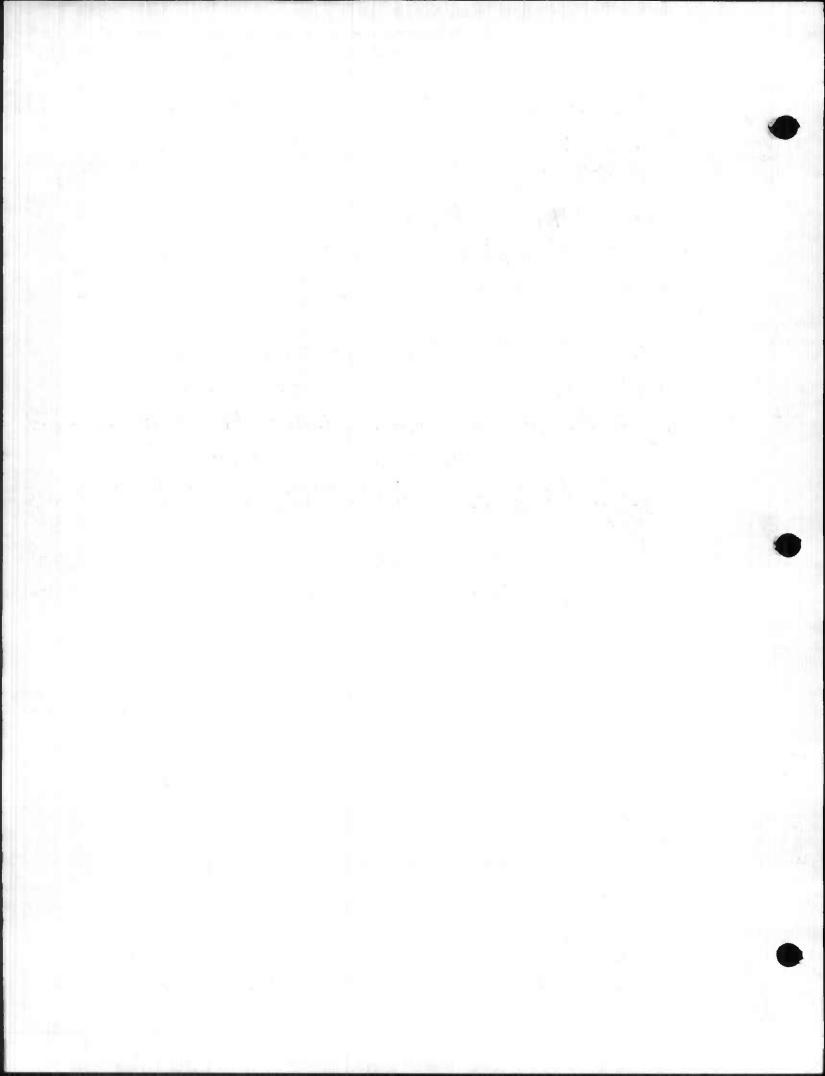
31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

900 Caton Avenue

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 9, 2000 10:40 A.M. Elizabeth Irene Grochowski 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Northwest Hospital Center Randallstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 26, 1 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Days 1□ M 21 F Months Yrs. 1926 Maryland 212-22-0338 73 Usual Residence of Decadent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Carrol1 Sykesville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1815 Vincenza Court 21784 United States 12. Wes Decedent Ever in U,S. 14. Rece - American Indien, 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces? 1 Yas 2 No If Yes, Give Year or Detes: Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Bottle Line Operator Seagrams 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence Virginia Walters Henry Augustus Bolte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Deer Cross Court Reisterstown, MD 21136 Larry W. Grochowski - Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 02/12/2000 Sykesville, Maryland 21. Signature of Furthral Service Licensee 22 Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, near failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequenca of) Interestiva or Integt nue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): t. A. Ilaten Due to (or as a consequenca of): Part If. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Apuno concreene or Ihm 24b. Were autopsy findings evallable prior to 24a. Was an autopsy performed? Chrome Obstructure Air may completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Tertifying Phyatcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Examiner physicien end the burial-transit the deeth certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical ettending pl signed by the e by Completed i certificata has b lirector, page 2 s funeral director, Be 0 this Certification: or Attending after death. 3 filled In 24 hours a Hospital Medical To the Hosp within 24 hor To the Fune completaly f

Physician

· /Medical

Examiner

Funeral

Director

r than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at

Directo

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Completed

Be

the Manylend

filed within 72 hours after death with

Hygiene.

Pages 1 and 2 should be filed with the state of the state

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year) FEB 1 1 2000 **DHMH 16 Rev 6/95**

29b. Signature end title of cartifier

Chincus m.0 32. Registrar's Signature 5310 OLD COURT oaks

29c. License number

129085

29d. Date signed (Month, Day, Year)

9

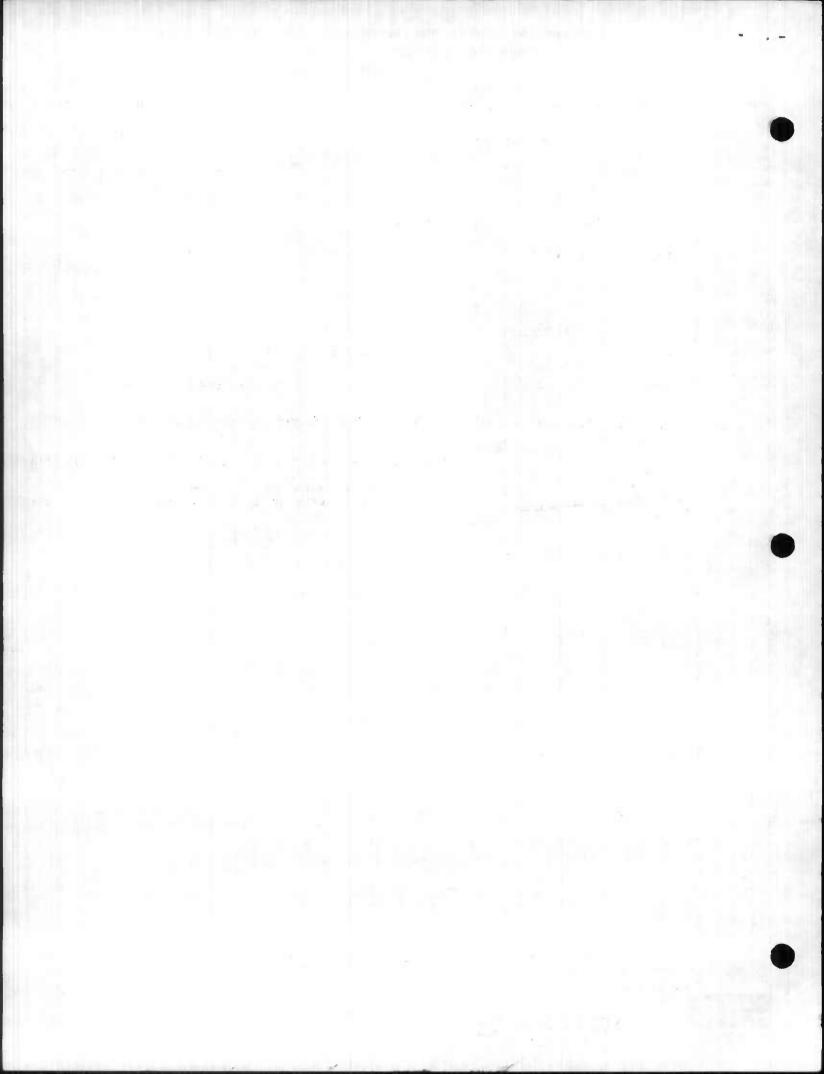
2000

February

J.

ender

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month **Physician** NNA 2000 02:25 /Medical 4c. County of Death Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** County Hospitai Howard Columbia GENERAL Noward 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Aga (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplaca (Steta or Foreign Country) **Funeral** 1□M 2₩F Months Days Hours Min. Director 213-22-1979 Nov.22 1918 Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f Maryland Howard Elkridge 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? finer must be b United States Funeral 21075 6621 Jeana Place 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene, other than filed within Elementary/Secondary (0-12) College (1-4or 5+) Machine Sales Office Manager altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental Mary Elizabeth Barrett George Gardiner Smith, Jr. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of of Health a till feet 27 is or other tra 5170 Ilchester Road Ellicott City, MD 21043 Carol Ann Cobb (Daughter) 20b. Place of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriat 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Lorraine Park Cemetery 2/12/00 Woodlawn, MD re of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur SPring Road Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death.) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a cardiac or respiratory arrest, Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final (AZDIOMYODATHY YEARS disaasa or condition resulting in death) **Examiner** Examiner YEMES ITRONIC OBSTRUCTIVE AULMONARY DISEASE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of). physician the buria Box 68760. Physician/Medical Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Nes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION. PNEUMOCOCCAL PHEUMONIA Records, à Completed 24b. Wera autopsy findings available prior to DEED VEIN THROUGOSIS 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attanding Physician: 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatienf 2 ☐ ER/Outpatienf 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Ptaca of Injury - At home, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida Mospital of 24 hours a Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical tely Within 2 \$ 29b. Signature and June of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2 138294 m m 09. 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) F. GIBBOUS

DHMH 16 Rev 6/95

State

Registrar

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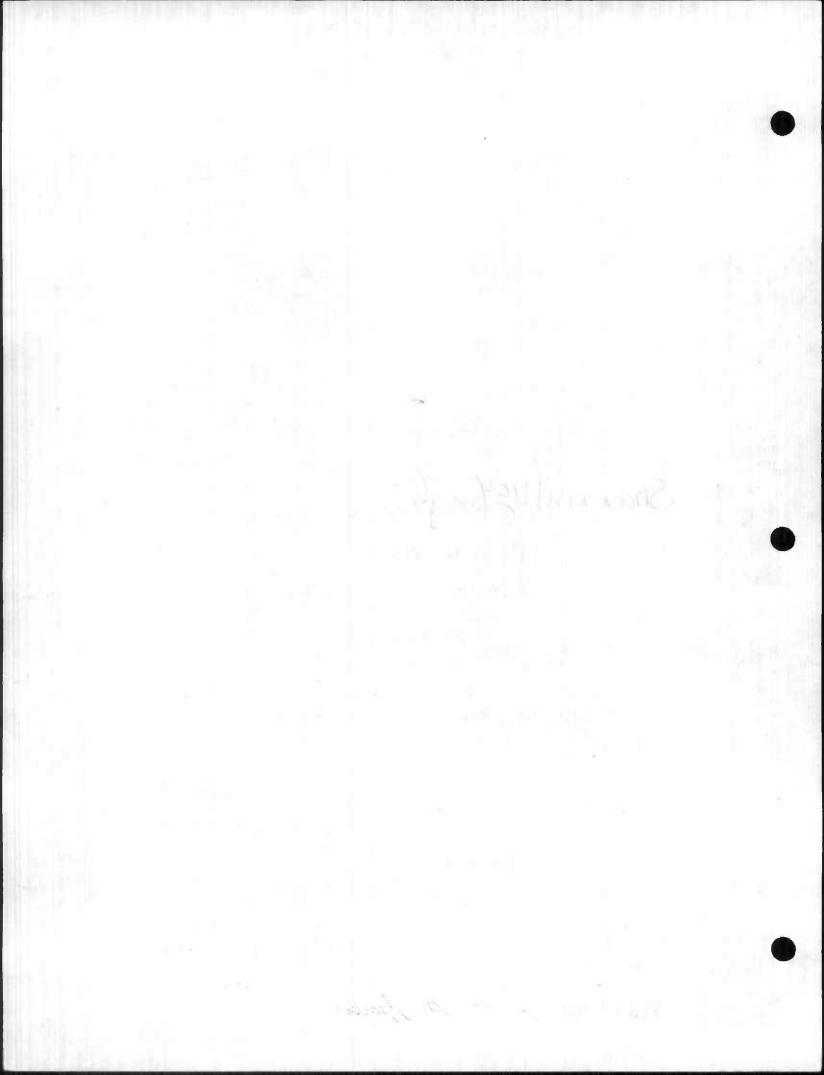
31. Date filed (Month, Day, Year) FEB 1 2000

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9501 OLI ANNAPOLIS RD, ELLICOTT CITY, MD 21042

WI

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item#9 perFH 6780 2/24/2000 FW AMEND#20b PER F.H. G780 2-23-2000 JAB Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 7, 2000 February Betty Nancy Gruber 5:00 A.M. /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 116 Magothy Bridge Road Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Tennessee Naryland **Funeral** Months 10 M 20 F 78 Yrs. 220-16-4183 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo 238-1 Md. Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 116 Magothy Bridge Road Herra 23a 21146 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried natural, or 1 ☐ Yes 2 1 No Specify: 21215-0020 þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6th 0 Machine Operator Vectra Baltimore, Maryland 17. Father's Neme (First, Middle, Last) permi. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any injury or other traumatic event 18. Mother's Neme (First, Middle, Meiden Sumame) Be Clay Singleton Lou Vernie Collins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Vukov (daughter) 116 Magothy Bridge Road Severna Park, Md. 21146 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 2/10/2000 4 ☐ Donetion 5 ☐ Other (Specify) Hill Cemetery

22. Name end Address of Fecility Cedar 2/10/99 Baltimore, Maryland 21. Signeture of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225

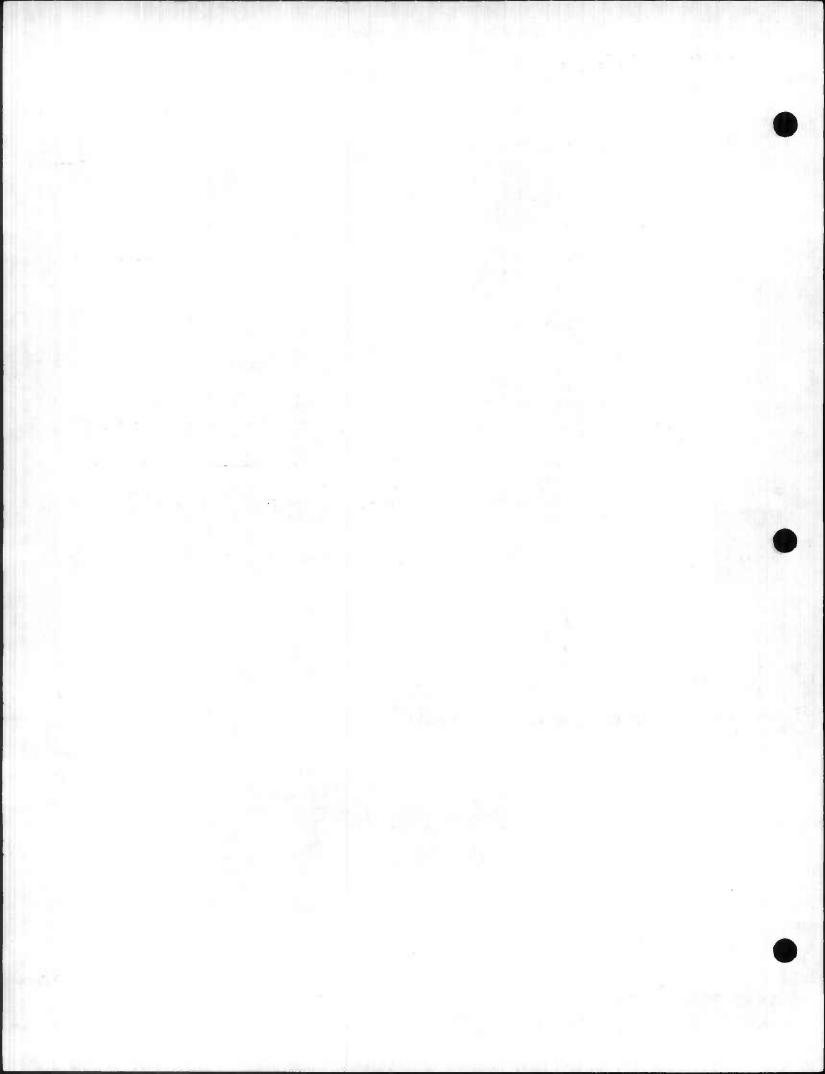
238. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · CHRONIC OBSTRUCTIVE LUNG 10 Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown KHEUMARUID HRAHRITIS py 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed The law 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical axaminer? Certification: To Be 26. Place of Death (Check only one) 1□ Yes 210 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 8 Other (Specify) this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Detural or Attending 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certified FEBRUARY 10, 2000 Myllen 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4th STESSET, BRETHORE, WARKOUD ZUZZ 3700 A. HI665 - SHEPKINGUM YAMULIU & 32. Registrer's signature 31. Dete filed (Month, Day, Year) State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death FESWARY 645 A Clarabell Gerber 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Harford County Fallston General Hospital Fallston 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1□ M 2以F Months Hours 84 213-62-8373 Yrs. Aug.11 1915 Maryland Usual Residence of Decedent 10s State 10h County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1⊠Yes 2□No n/a Md. 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1303 S. Hanover Street 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Owner 8 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Martha K. Spiker Charles F. 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1824 Arabian Way, Fallston, Md. 21047 Charles Gerber (Son) 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1) Buriat 2 ☐ Cremetion 3 ☐ Removel from State Baltimore, Md. Loudon Park Cemetery 2/10/00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 nen 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) JEUMONIA WEEK Due to (or as a consequence of) 10 DAYS MOKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 1 | Yan 2 No 3 Probably 4 Unknown CORDIO UNSTALLAR DIRIALA 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy DINO 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 3 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Chpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury el 28d. Describe how injury occurred Watural 5 Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide

Physician/Medical Examiner physician end s the buriel-transit The lew requires that the deeth certificate be executed by Completed After this certificate has be funeral director, page 2 a edical Certification: To Be

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours efter death with the Marylas nest of Heelih and Mentel Hygiene.
and: If flow 27 is marked other than "natural", or flows 23e or 28e-f show any or other theumatic event, the land of Emirical most be notified.

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Department of
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Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760. 24 hours effer death.

Funeral Director: A filled in by Hospital

> State Registrar

within 24 hor To the Fune completely fi

29a. Certifier

(Check only one)

29b. Signature and the of central

Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as stated.

Con the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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29d. Date signed (Month, Day, Year) 2000

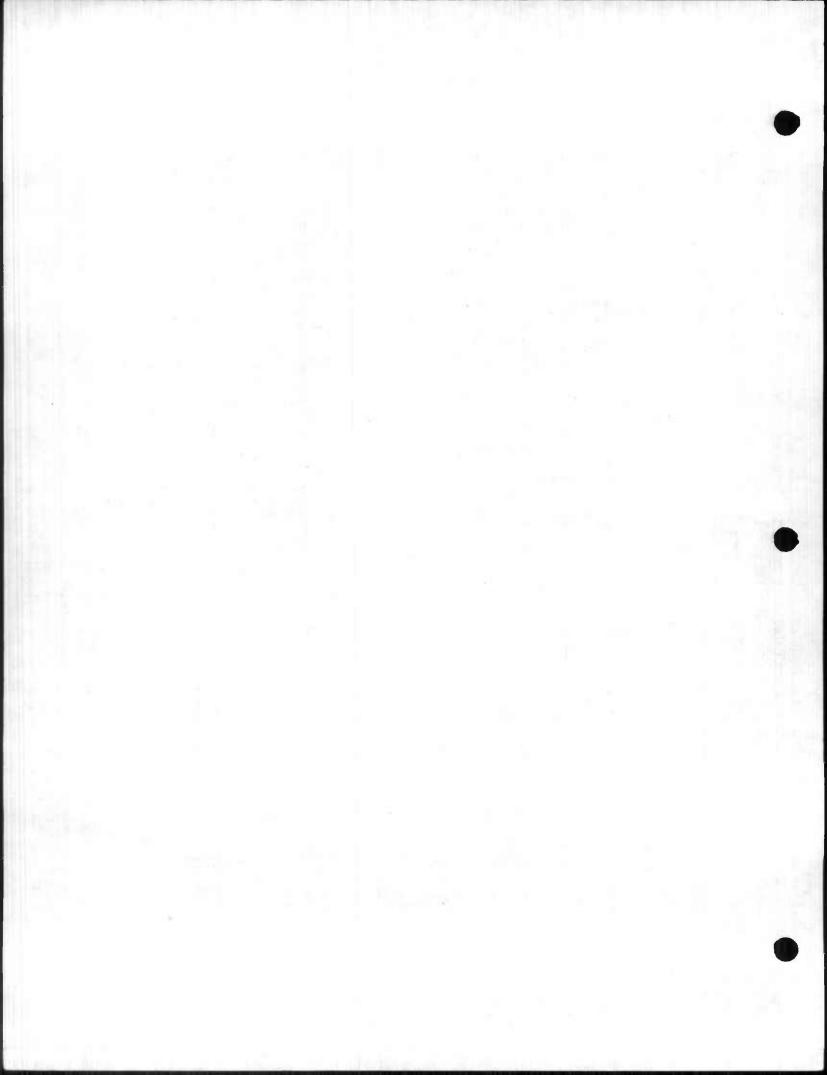
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILLIPS

2005 LIDUR SARING 31. Date filed (Month, Day, Year) FEB 1 1 32. Registrar's Signature 2000 Seneva

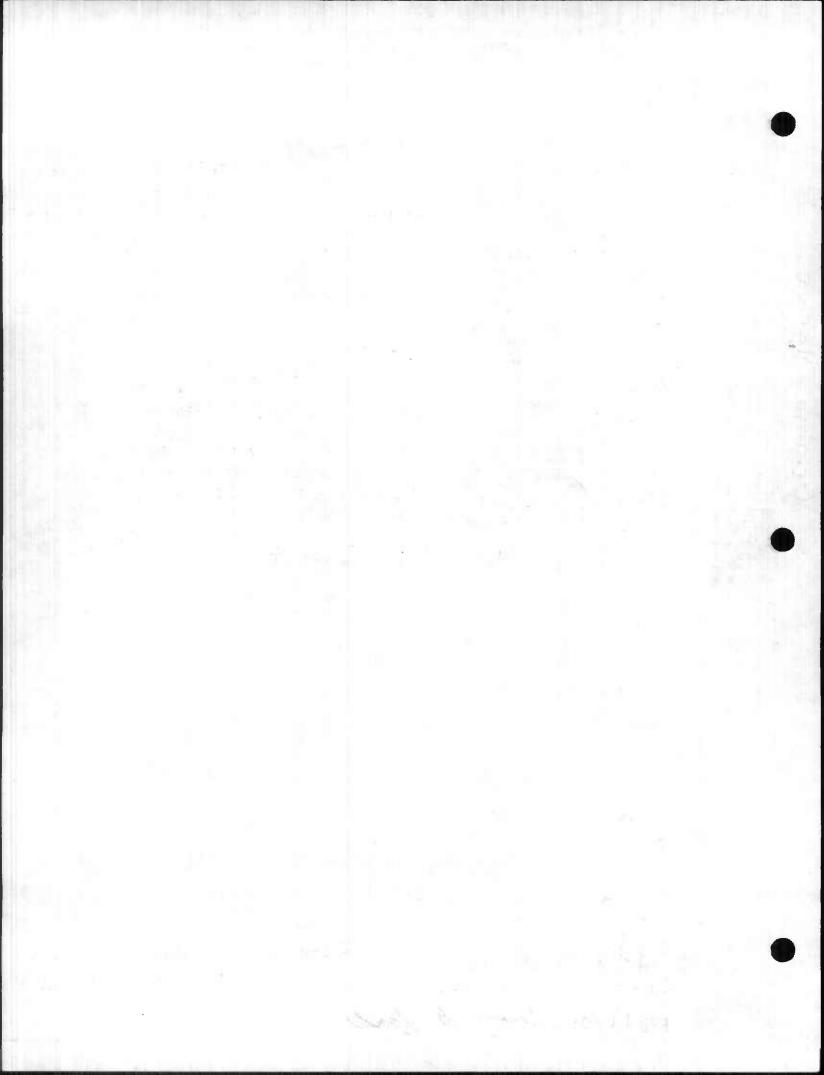
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie | Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Mariva Grinina Februar 04 2000 0517 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2401 West Belveder timore Hospita 8. Data of Birth Dev Year 910 If Under 1 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign Country) **Funeral** 10 M ZOF Days 89 220-39-7979 Director Russia Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 X Yas 2 □ No 28a-f Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Russia 21215 3615 Fords Lane, Apt. 718 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Nevar Married 2 Married 5 Maryland 21215-0020 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within 7 Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Own home 12 Housewife 18. Mothar's Name (First, Middle, Meiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be nent of Health and Mental Yelena Strelnikova Nikita Kurochkin 19b. Melling Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 3615 Fords Lane, Apt. 718, Baltimore, MD 21215 19e. Informent's Neme/Ralationship (Type, Print) Yelena Grinina Daughter Baltimore, 20a Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata cematary, crematory or other placel Department of 1 ♥ Burial 2 Cremation 3 Removal from Stata 2/6/00 Reisterstown, MD All Saints Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensas 22. Nama and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner Dua to (or as a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): USB 88 Por signed by the at 1 be detached for P.O. 1 Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24b. Were autopsy lindings available prior to page 2 should 24a. Wes an autopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: director 8 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Natural 5 Panding 1 Yas 2 No 24 hours after death. Invastigation 2 Accident 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only within 2 To the 29b. Signatura lile of certifiar 29c. License number 29d. Date signed (Month, Day, Year) nicaro addrass of person who completed cause of death (Item 23a) (Type, Print) West belvede Mc)ean Tarr A.O. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar **DHMH 16 Rev 6/95**

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Cronce Mene James Fe bruary 5,2000 ation of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosemont Fallston Drive Har 100 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 10 M 20 F Months Hours 26-32-552 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Hartord 1 Yes 200No MD Fallstor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 1014 Rosemont 21035 Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) C. Arringtor Snow obert Lla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marvin B. Gonce-Spouse 1014 Rosemont Drive Fallston, mD21085 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetary, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb.8, 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland mem. Gardens 12000 22. Name and Address of Facility Evans Chapel-Bel Air, P. A 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill mb eati 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death min les tmmediate Causa (Final diseasa or condition resulting in death) Oscaro anceg Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 25 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yas 2 2 No 1 Yas No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yas 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner The law requires that the death certificate be executed Box 68760. P.0. Records, or Attanding

Physician

/Medical

Examiner

10a. State

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel hygiene. Important: if them 27 Is marked other than "natural", or frem eny injury or other traumatic avent, the Hedical Exeminations.

Physician

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Physician/Medical Examiner

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4 ☐ Homicide

29b. Signature and title of certified

29a. Certifier

Baltlmore, Maryland 21215-0020

Director

Funeral

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Completed hes! certificata Division of VItal edical Certification: To After this death. Director: / offer To the Hospital
within 24 hours e
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completely filled

State Registrar

DHMH 16 Rev 6/95

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29c. License number 118487

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

, 2000

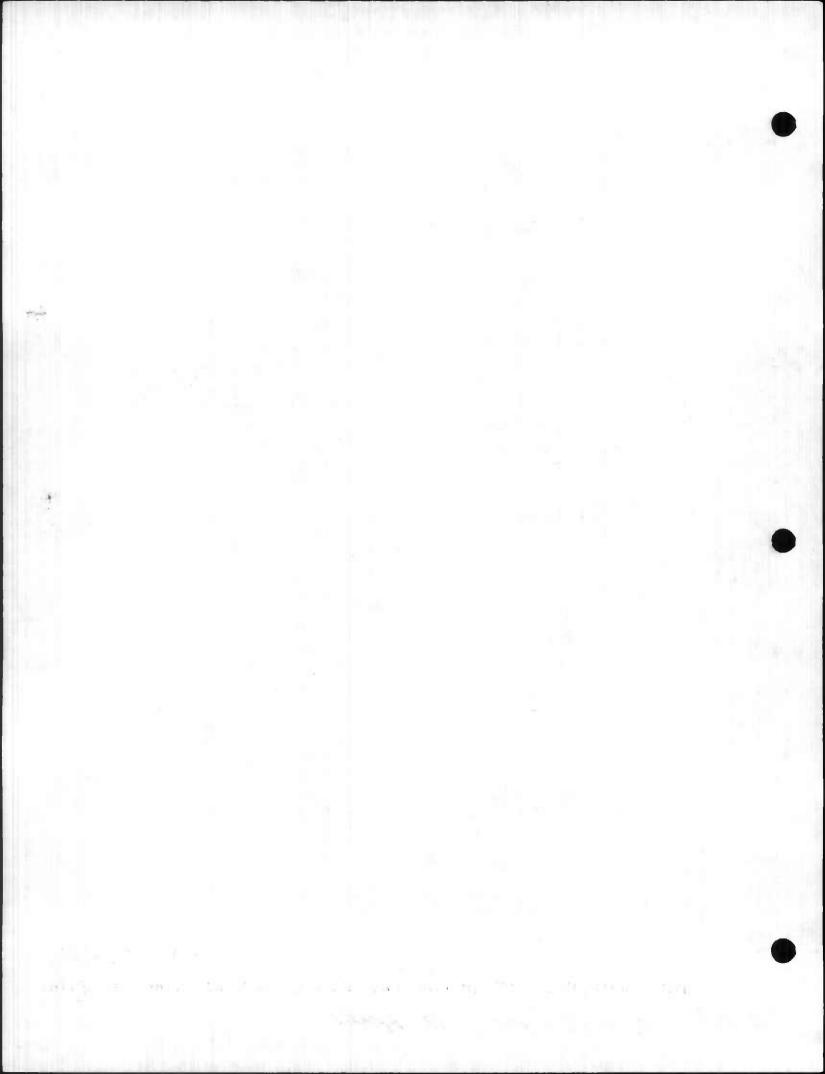
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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

6830 HOSPITAL DE. STE. 206 FRANKLIN SQUARE HOSPITAL

31. Date filed (Month, Day, Year) 32. Registrar's Signature

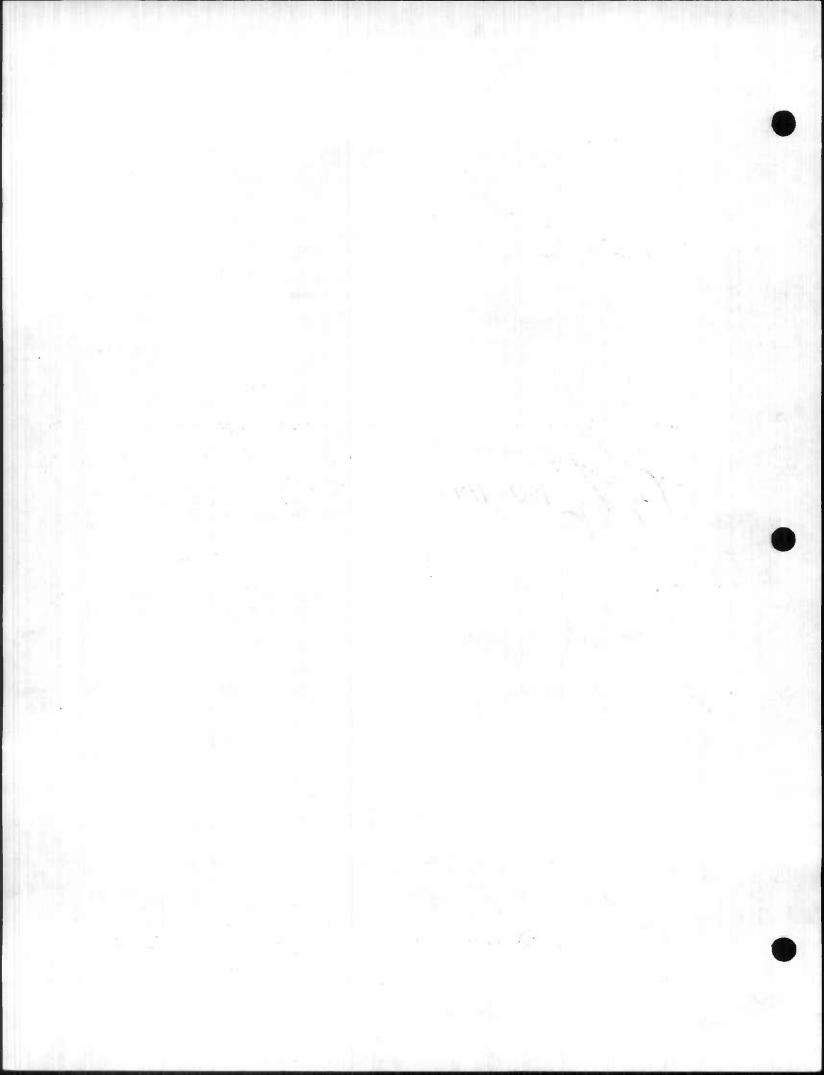
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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| kaminer | 4a Facility | Name (If I | ot institution, | give str | eet and nu | umber) | | | | | 4b. City, To | wn, or Lo | cation of Dea | | | of Death | | |
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| neral ector | | Security Nun | | 6. Sex | 4 2 F | 7. Age (Ir 98 | n yrs. last l | birthday) Yrs. | If Under | er 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of B (Month, D 09/24 | irth lay, Year) 1/190 | 1 | 9. Birthpi Coun Penn | lace (Ste try) | te or Foreig |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Feb 10,2000 Norma Ada Hammel 1:15 pm. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Heritage Center Dundalk Baltimore If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 20 F Days 216-14-7596 Feb, 24,1922 Usual Residence of Dece 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 Brentwood 21222 Ave USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 Dato Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumame) 12 VYS Housewife Herman Grumback Lillian Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Edward Hammel Husband 7001 Brentwood Ave, Dundalk, Md. 21222 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State Feb 11 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2000 Catonsville 21/Streature of Fatheral Service Licensee 22. Name end Address of Facility Connelly Funeral Home of Dundalk, P.A. Enter the disease, or complications that saused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMEMTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ERCHOLESTEREMIA Due to (or as a consequence of) THEMIA Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28h Time of 28d. Describe how injury occurred

Physician/Medical Examiner The law requires that the desth certificate be axecuted Box 68760, the signed by the attending p Division of Vital Records, P.O. Completed by paga 2 this certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director; I 8 Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

289-7

8 23a

al Hygiena. I other than "natural", or items event, the Medical Exercion: or

21215-0020

Baltimore, Maryland

Pages 1 and 2 should be illed within 72 hours after of the first of Mental Hygiene.
Intil them 27 is marked other than "netural", or the lay or other traumed event, the Medical Examination

Department of important: If any injury or

Physician

Examiner

/Medical

25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

San volu U sulle 31. Date filed (Month, Day, Year)

2000

FEB 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

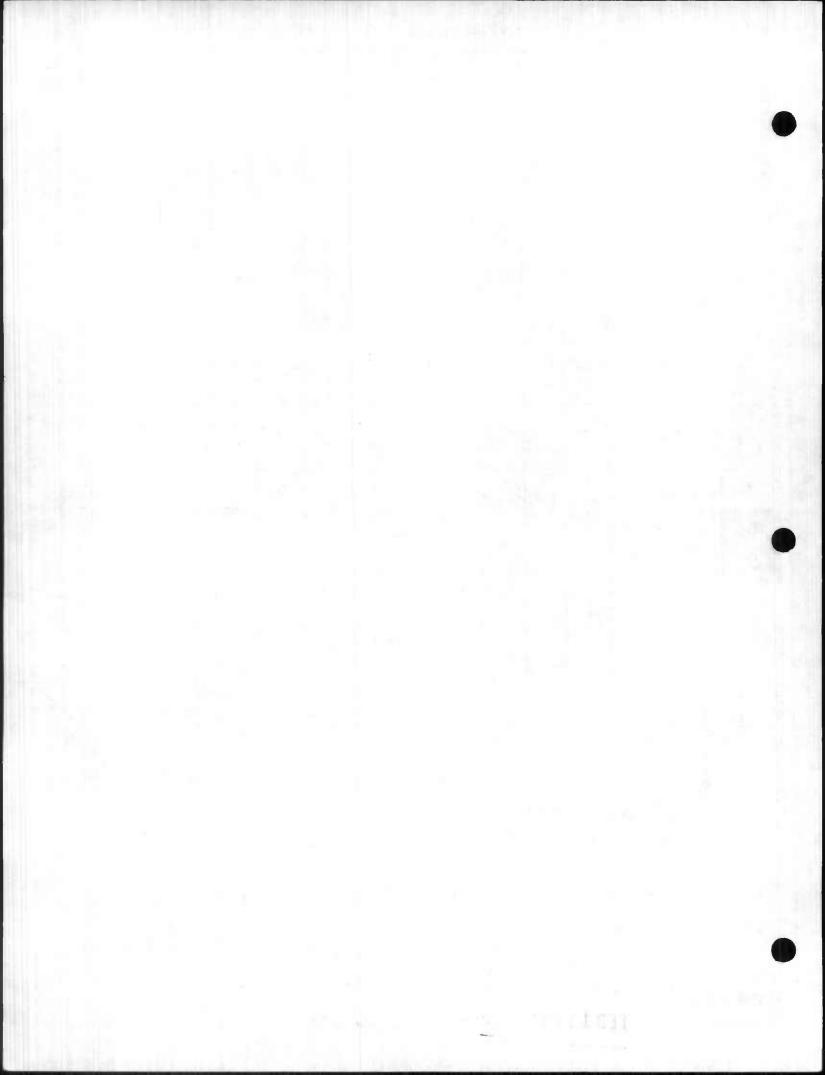
29b. Signature and title of certified

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Bultine MD 21222



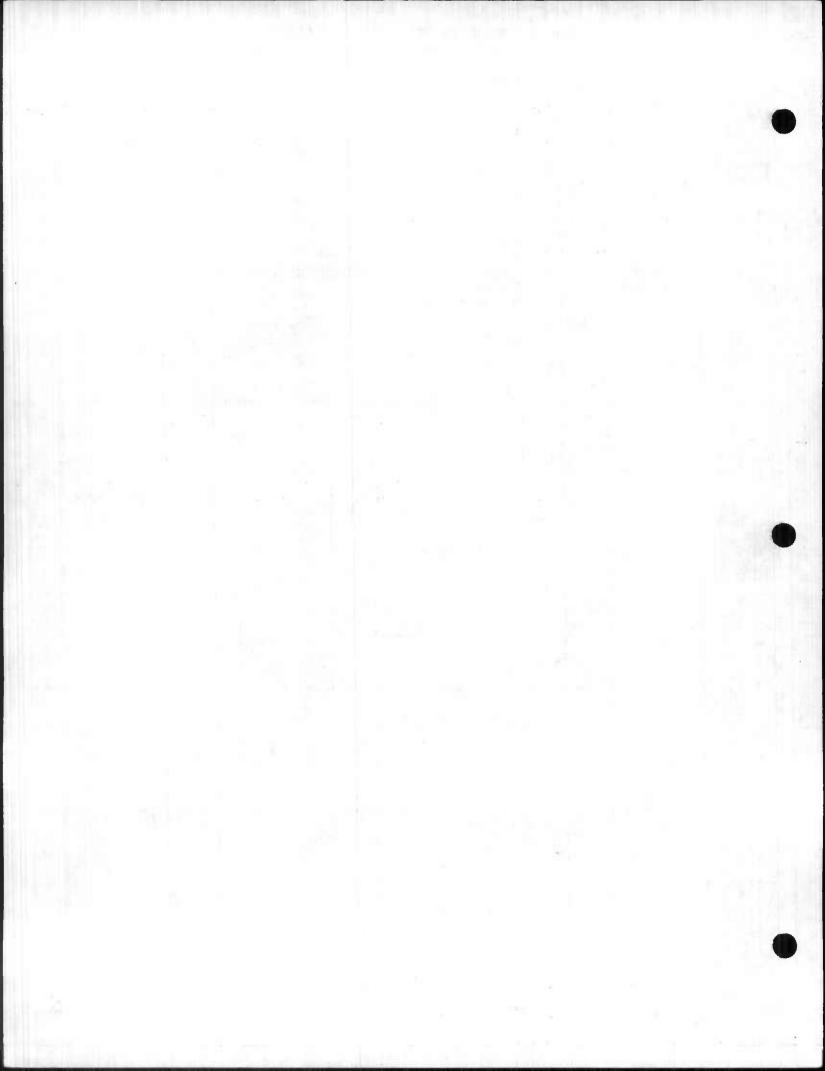
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Year Month **Physician** DAVID WILLIAM HEISIG February 8, 2000 /Medical 12:55 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 □ F Yrs. 59 March 8, 1940 Wisconsin Director 395-34-0701 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 늄 904 Shelburne Road 21015 U.S.A. Funeral Berna 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 NYes 2 No If Yes, Give Year or Deles: Vietnam 8 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 filed within Elementery/Secondary (0-12) College (1-4or 5+) 4 years Lt. Colonel U.S. Army Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Mental 7 is marked of traumatic evi Pages 1 and 2 should nent of Health and Men 2 Wallace Heisig Phenette Howe 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If Item 27 I Belinda Heisig (Wife) 904 Shelburne Road, Bel Air, MD 21015 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State Department of Important: If any injury or 2/14/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finet PROSTATE CANCER disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): US0 88 signed by the aid be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 Yes 2 No certificate of Vitai or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Yes 2 No 27. Menner of Death Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Netural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29e. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical pletely (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) Lin 043725 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TARIQ MAHMOOD 31. Date filed (Month, Day, Year) 32. Registrar'e Signature State FEB 1 1 Zun Registrar

DHMH 16 Rev 6/95

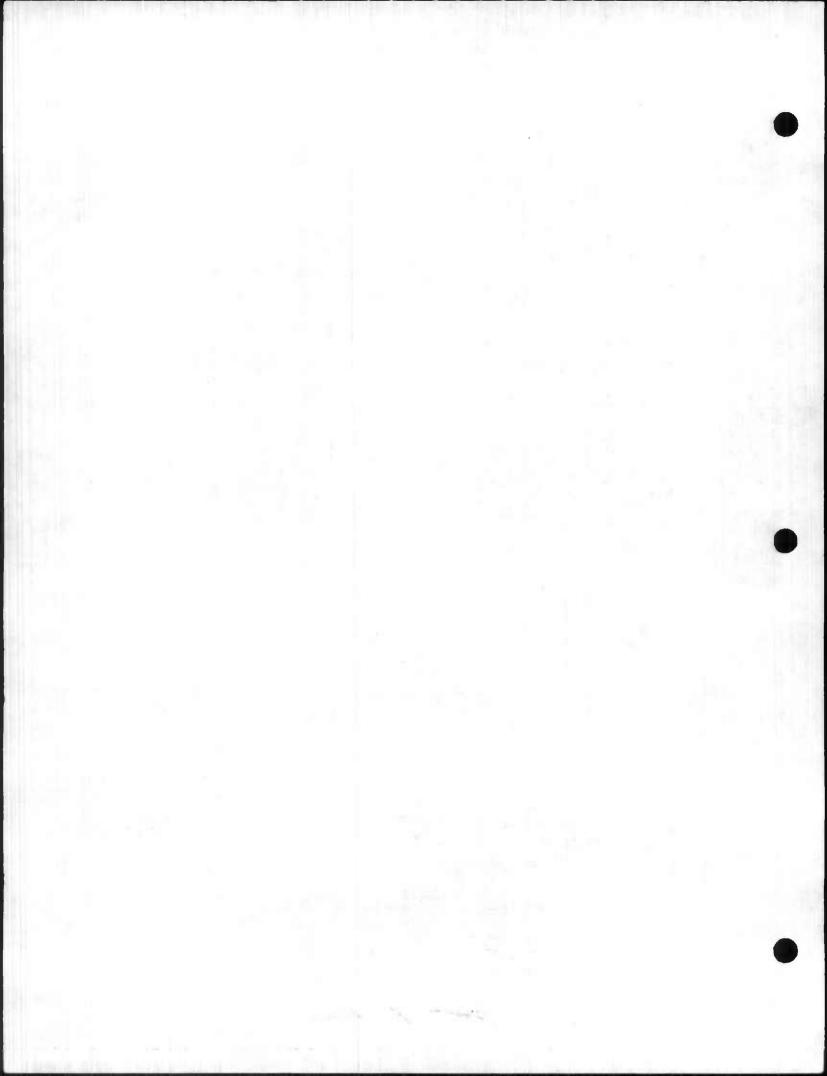
Pebruary

David Heisig



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

| 4 Short Security Number of the distribution, given assert and number of 2.14 East Chase Street, 1st Floor 1921 April from state in the Chase Street, 1st Floor 1921 April from state in the Chase Street, 1st Floor 1921 April from state in the Chase Street 1921 April from state in the Chase Street 1921 April from state in the Chase Street 1922 April from 1922 April f | ian | 10-12-14-11 | e (First, Middl | le, Last) | ** | | to la | | | 2. Date of Do | | Vear | ne of Death |
|--|--|--|--|---|--|--|--|--|--|---|--|---|--|
| 2.14 East Chase Street, 1st floor S. Scold Security Number Unknown S. Scold Security Number Unknown Unknow | ical | | John Horvath Facility Name (If not institution, give street and number) 4b. C | | | | | | 4h City Town or I | 1 | | | 10 P.M. |
| United Traditions of Shooters United Traditions of Shooters Inc. County Inc. Cou | ner | | | | | | oor | | | | | | |
| No. State and Number 100. Exp. Compt more of Location 100. Top Code 100. Exp. Code | | Unknow | 'n | | | | | | | (Month, D. | rth ay, Year) 5-52 | 9. Birthplace (Si Country) | tate or Foreign |
| 10. Spread and Number 21.4 East Chase Street 22.2 List Basts Chase Street 22.4 East Chase Street 23.6 Where the Prince of Control (Specify Yea or No. 11 Yes, specify Chase, Mexican, Practic Research Cirgor) (Specify Yea or No. 12 Yes, Specify) 25.6 November 5 Secretion 26.6 November 5 Secretion 27.6 November 5 Secretion 28.6 November 5 Secretion 29.6 Nov | | | | | | 10c. C | City, Town or Lo | ocation | | | | 10d. Insi | de City Limits |
| 11. Martial Status 11. Martial Status 12. Was Decoderf Fer in U.S. 12. Was Decoderf Status Chign? (Specify Yes or No. 12 Was Decoderf Status Chign? (Specify Yes or No. 12 Was Decoderf Status Chign? (Specify Ves or No. 12 Was Decoderf Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign? (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Ves or No. 12 Was Decoder Status Chign?) (Specify Chigns.) (Speci | | MD | NA | | | В | altimo | ore | | | | ₩□ | Yes 2□No |
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| 19th Answer (Pirat Models, Assignment) 19th Meditor's Name (Pirat, Addies, Assignment) 19th Informati's Name (Pirat, Addies, Assignment) 19th Information 19t | mpleted | Elementary/Seco | only higher andary (0-12) | st grade com | pleted) ollege (1-4d | or 5+) | | | pation during most of wor ad) | king | | | |
| The content of the content is a consequence of content is continued to the cause of death? Due to (or as a consequence of): | | | | | rs. | | 000 | | 18. Mother's Nan | | e, Maiden Suma | - | |
| Robert Smith 214 E. Chase Street Baltimore, Maryland 20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of Disposition) Date 20c. Location - City or Town, State 20b. Place of Disposition Cemeter Py 02-12-2000 Baltimore, Maryland 21202 21. Signature of Inneral Service Locations Cemeter Py 02-12-2000 Baltimore, Maryland 21202 WM. C. March Facility Baltimore, March Facility WM. Was an autopsy 24b. West autopsy March Facility WM. Was an autopsy Compilation of cause of death? WM. Was an autopsy WM. Was an | | John | | Н | ill | | | | | | | | |
| Buriel 20Cometion Contention Contentio | | | | | rint) | | | | | | | | |
| 23. Signeture of Funeral Service Licensee 24. Name and Address of Facility 25. Name and Address of Facility 26. Plant Enter the Gasess, or complications that caused the deeft. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate A | | | | 3 □Remov | al from Sta | ate l | cemetery, crei | matory or other pla | | | | | |
| Sequentially list conditions Sequentially list conditions or respiratory areast Approximate | | | | | | G | | | | | | | |
| Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part II. Part III. Other algoriticant conditions contributing to death | | 21. Signature of Po | PROPERTY OF THE PROPERTY OF TH | // | 1 | 1 | | | D 6 | | | - | |
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| 25. Was case referred to medical examiner? 1 \(\text{L} \text{ Yes} \) 2 \(\text{No} \) No Hospital: \(\text{ Inpatient} \) 2 \(\text{ ER/Outpatient} \) 3 \(\text{ DOA} \) Other: \(\text{ Injury} \) 4 \(\text{ Nursing Home} \) 5 \(\text{ Residence} \) 6 \(\text{ Other} \) (Specify) 27. Manner of Death \(\text{ Injury} \) 28a. Date of Injury \(\text{ Injury} \) 28b. Time of Injury \(\text{ Work?} \) 1 \(\text{ Yes} \) 2 \(\text{ No} \) No injury occurred 28c. Injury at Work? \(\text{ Work?} \) 1 \(\text{ Yes} \) 2 \(\text{ No} \) No injury occurred 28c. Injury at Work? \(\text{ North Residence} \) 6 \(\text{ Other (Specify)} \) 28c. Injury occurred 28c. Injury at Work? \(\text{ North Residence} \) 1 \(\text{ Yes} \) 2 \(\text{ North North North Pert and Number or Rural Route Number, City or Town, State} \) 28c. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? \(\text{ North Residence} \) 1 \(\text{ Yes Town, State} \) 28c. Location (Street and Number or Rural Route Number, City or Town, State} \) 28c. Location (Street and Number or Rural Route Number, City or Town, State} \) 28c. Location (Street and Number or Rural Route Number, City or Town, State} \) 28c. Location (Street and Number or Rural Route Number, City or Town, State} \) 28c. Location (Street and Number or Rural Route Number, City or Town, State} \) 28c. License number \(\text{ 2.5 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steled. 28c. Injury at Work? \(\text{ 1.7 Work of the Cause(s) and menner as stated.} \(\text{ 1.7 Work of the Cause(s)} \) 28c. License number \(2.7 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steled. 28c. License number \(\text{ 2.7 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occur | | Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) to | (Final in | a b c d | | Due to | (or as a consector as | quence of): quence of): | | 23b. Did | tobacco usa co | Onset | use of death? |
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | A Decident to the second | -41 | (| Certifica | ate of | Death | | g. No. | 0 | 7 6 6 4 | | |
|--|--|--|--|---------------|----------------------|---|---|---|---------------------------|---|--|--|
| Physician | 1. Decedent's Neme (First, Middle, Last) | | | | | | 2. Date of Deat Month | Day Year | | 3. Time of Deeth | | |
| /Medical | Mabel Darr | | .1 | | | | Februar | - | | 2:57 AM | | |
| Examiner | 4e Facility Name (If not Institution, giv | | 717 0 | | | 4b. City, Town, or L | | 4c. County | | | | |
| | Salisbury Center | | | | | Salisbur | 4 * | Wico | mico | | | |
| Funeral Director | 5. Social Security Number 6. S 243,14,8367 Usual Residence of Decedent | Sex 7. Age | (In yrs. last birth | Month | ler 1 Year s Deys | Hours Min. | 8. Deta of Birth (Month, Day, Oct. 23 | | | lace (State or Foreign try) th Carolin | | |
| show abow ed.at | 10a. Stete 10b. County | | 10c. City, Town | | | | | | to | od. Inside City Limits | | |
| or 28a-f | Maryland Wicomic | 0 | Sali | sbury | | | | | | | | |
| th with the Maryla 23s or 28s-f sho unt be notified at all Director | 10e. Street and Number | | | 10f. 2 | ip Code | | 11 | Og. Citizen of \ | What Coun | try? | | |
| 123 Part 123 | 150 Shammrock | | | | | 804 | | nited : | | | | |
| alt, or here 23 Examiner must by Funeral | 11. Merital Stetus 1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced | 12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Giva Yeer or Detes: | | | | lispanic Origin? (Sj an, Mexican, Puerto Specify: | pecify Yes or No- p Rican, etc.) | Bled | e-America ck, White, e | etc. | | |
| an "naturn Andical J Appleted | 15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12) | | e completed) (Give kind of work life, DO NOT use | | | during most of worl | king | 16b. Kind of Br | usinass/Ind | lustry | | |
| ind within typiene. Ner then II. the Me | 9 | | | sembly | Wor | ker | | Westin | ghous | e | | |
| Be Be | 17. Fether's Neme (First, Middla, Last, | | | | | | e (First, Middle, N | | 10) | | | |
| Mental Me | James Thomas Darr | ell_ | | | | Matti | e McCall | um | | | | |
| and a | 19e. Informent's Neme/Ralationship (| Type, Print) | | | | and Number or Ru | | | | Code) | | |
| and asim | Steven Smith (Gra | indson) | 150 | Sham | nrock | Drive Sa | alisbury, | MD 21 | 804 | | | |
| Pages 1: hent of He ant: If hen ary or oth | 20e. Method of Disposition 1 Description 3 Communication 5 Other (Specification) | | | crematory o | r other pla | ce) rial Park | | Dorse | | | | |
| permit. Departi Import any inj any inj any inj | 21. Signatura of Funeral Service Licer 23a. Pert1. Enter tha disease, or com shock, or heert failura. List only | ney | myle | 2719 1 | Hammo | ss of Fecility uneral Ho nds Ferry | Road La | nsdown | | 21227 Approximate | | |
| Physician /Medical Examiner | Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if each leading to immediate | b. 20 | Oue to (or as a co | 4 | | ias . | pola | 42 | 9 | ito, | | |
| at the death certificate be executed by the attending physician and letached for use as the burial-transit Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algnificant conditions of | d | Jue to (or as a co | | / | an in Part I | 23h Did to | harco man co | atribute to | the cause of death? | | |
| requires that the death cer seen signed by the attendin should be deteched for use eted by Physician/A | | | THOUTOSOMING WITE | no underlying | , cause giv | on in tall i. | | | | Debly 4 Unknown | | |
| been s should | | | | | | | 24a. Wes en | ned? | cor of c | re autopsy tindings ailable prior to appletion of cause death? | | |
| S Page 8 | | | | | | | 1 🗆 Ye | / | 1 [| Yes 2 No | | |
| ician: certific rector | 25. Was casa referred to medical examinar? | Hospitel: | | | Ott | | th (Check only on | | | | | |
| Physician: this certific ral director. | 1 Yes 2 No | 1 Li Inpatier | | | JUA | 4 LUMBISING H | oma 5 Raside | | | () | | |
| pital or Attending Physician: The law man after death. The Director: After this certificate has fined in by the funeral director, page 2 il Certification: To Be Comp | 1 Accident 5 Pending investigation | n M | | | | y at k? Yas 2□No | | | | | | |
| Hospital or Attending A hour after death. Funger Director: After any first in by the fune silical Certification | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| E FEE | | ysician: To the best of niner: On the basis of end menner stet | examinetion and/ | | | | | | | | | |
| Med Med | 29b. Signature and titla of certifier | 10 | | 2 | 9c. Licens | e number | 2 | 9d. Dete aigne | d (Month, I | Day, Year) | | |
| 11/2 | 1 A | 1/1 | | | 0 9 | 2934 | 9 | 2/8/ | 10 | | | |
| (H) | 30. Name end address of person who | completed causa of de | ath (Item 23a) (T | ype, Print) | | 1-1 | 1 | 1 9/0 | V | | | |
| 4 | | | | | CALT | anina an | 27.004 | | | | | |
| State | WILLIAM ROBINS, M 31. Dete filed (Month, Day, Year) EER 1 2000 | 32. Registra | 's Signetyre | JOR. | DALLA ALLA | DOUKY, MD | . ZISU4 | | | | | |

Bill second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Name (First, Middia, Last) 2. Date of Death 3. Time of Death ohn ouis 12:59 P.M. - ebruary 2000 4c. County of Death 4a Facility Name (if not institution, giva street and number 4b. City. Town, or Location of Death Baltimore HD Har DOF er If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Months Hours 214-30-4308 66 31, 1933 Maryland Usual Residence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yas 2 No Lansdowne 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Imperial Court 21227 United States 12. Was Decedent Ever in US Armed Forces? 1/1954 1%194s 2 No If Yes, Giva 1/1956 Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, White, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working iffa. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Louis John Hoehl, Sr. Caroline Evelyn Nizer 19a. tntormant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 912 Imperial Court Lansdowne, MD 21227 Edna C. Hoehl (Wife) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ₺ Burlal 2 □ Cramation 3 □ Ramoval from Stata MD Vet. Cemetery Crownsville2/14/00 Crownsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility Ambrose Funeral Home of Lansdowne Stample 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part1. Enfar the disease, or complications that caused the death. Onot entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Finel diseasa or condition rasulting in daath) 60 min. Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last boll Dua to (or as a consequence of): bdomina Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ≥ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 50 m 25. Was casa reterred to medica axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) Hospital: 2 No 1 Pras 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Deta of tnjury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 BNatural 1 Yes 2 No 2 ☐ Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicida Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, daath occurred at tha time, date end place, and due to the cause(s) and mannar as stated.

[Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mannar stated. 29a, Certifier (Check only one)

Examiner The law requires that the deeth certificate be execut Box 68760, P.O. Records, Division of Vital or Attending Physicien: after death Director:

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23s or 28s-f show Examiner must be notified at

"natural", or items 23s

al Hygiene.

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event abota.

Physician

/Medical

physician and the burial-transit

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Physician/Medical Examiner

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Completed

Certification: To Be

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Completed

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filed within 72 hours after death

Baltimore, Maryland 21215-0020

24 hours a Medical completely within 2 \$ 0

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State Registrar

31. Data tiled (Month, Day, Year) 1 1 FEB

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29b. Signatura and titla of certifier

17 0 32. Registrar's Signatura

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Gerald

Sparks

ORIGINAL

29c. License number

3787

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29d. Date signed (Month, Day, Year)

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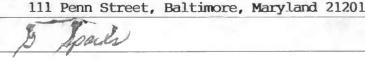
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29b. Signetura end title of certifian

31. Date filed (Month, Day, Year) 32. Registrar's Signatura

Urute no 30. Name end address of patient who completed cause of death (Item 23a) (Type, Print)

hutema



29c. License number

O.C.M.E.

29d. Dete signed (Month, Day, Year)

February 09, 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) Date of Death 3. Tima of Death **Physician** burce /Medical 4b. City Town, or Location of Dea Name (If not institution, give street and number) Examiner era If Under 1 Yaar If Under 2 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Days 110 M 2□ F Yrs. 80 Director 216-18-5736 11 1919 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examinat must be notified at 1 XYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1434 Marshall Street 21230 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 M Yes 2 No WWII If Yes, Giva Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: white λq 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gas & Electric Co. Mechanic 12 0 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 12 should be fill h end Mental H is marked oth Daisy Hance Gourly Hance 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Peges 1 and 2 st Department of Health end Important: If Item 27 is n any Injury or other traun Martha B. Hance (Wife) 1434 Marshall Street, Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Removal from State Glen Haven Memorial Park 2/14/00 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee elton 130 E. Fort Ave. Baltimore, Md. 21230 nestina 0 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between **Physician** /Medicai fmmediate Ceuse (Finel disaese or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last burial-tran and Box 68760. physician Physician/Medical the Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. 1 Yee 2 No 3 Probably Nhknown signed by þ Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed nisufficiency 2 No 1 Yes 2 TRo Division of Vital I Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) or Attending Patter death.

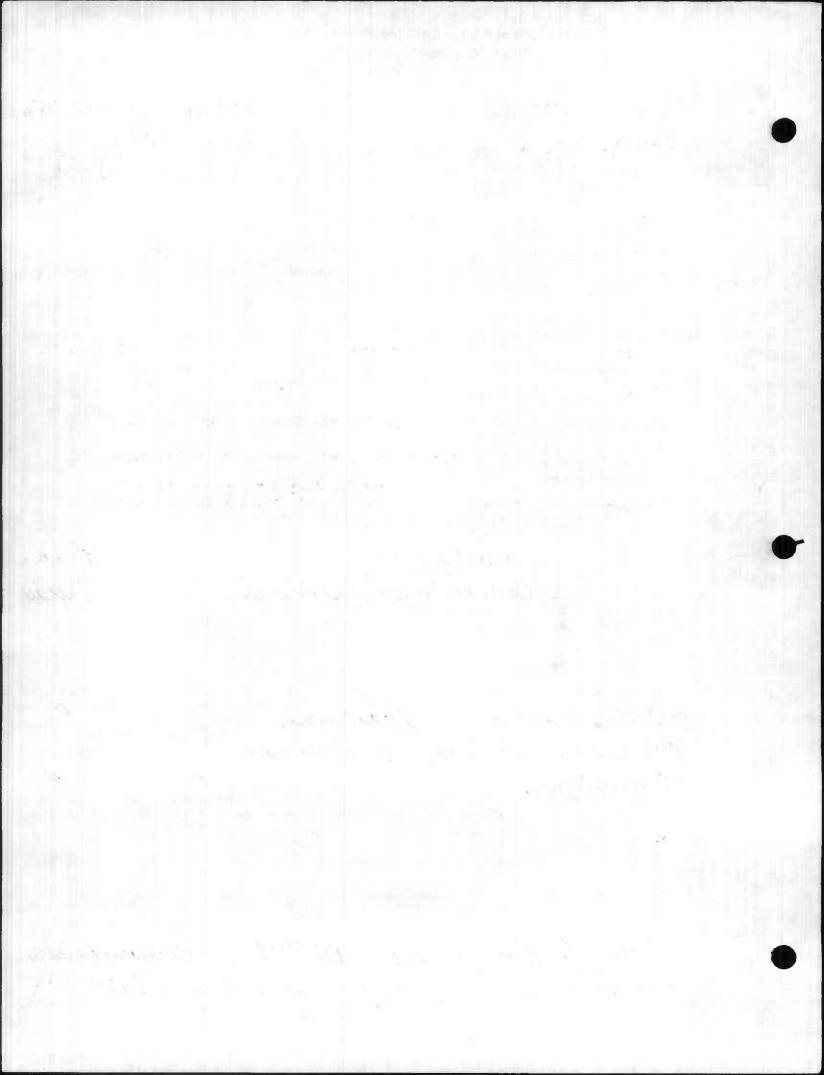
Director: After t 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatura and title of certifian 29c. Licanse number 29d Date signed (Month, Day, Year) a, Print)

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St Paul Pl Balton

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death **Physician** Month Lucille M. Hardrich Feb. 3:18 A.M. 10 2000 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Undar 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Sociel Sacurity Number 9. Birthplace (Stata or Foreign Country) New York 7. Age (In yrs. lest birthday) **Funeral** 1□ M 20 F 120 14 3532 77 Yrs Director March 14, 1922 New Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Anne Arundel Annapolis 1 Yas 32 1 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Winslow Court 21403 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 14. Race - American Indien, Black, Whita, atc. 13. Wes Dacedant of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: 1 ☐ Naver Married 2 ☐ Married White 1 ☐ Yas 2 ☑ No à Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Anna Potson George Koenig 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Hardrich Son Winding Ridge Road Odenton Maryland 21113 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Feb. 11, Date 2000 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Crownsville Maryland Maryland Veterans Cemetety 22. Nama and Address of Fecility eny in Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23e. Pert1. Entar tha disaasa, or complication, thet caused the daath. Do not anter the moda of dying, such as cardiec or respiretory errest, shock, or haart failura. List only ona causa on aach lina. Approximete fntarval Batween Onset and Deeth Physician /Medical fmmediata Causa (Final diseasa or condition rasulting in daath) Examiner Dua to (er es e consequence offi Examiner Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseesa or Injury that initiated avants Physician/Medicai that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 10 Yee 2 No 3 Probably 4 Unknown BRILLA ð 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical axeminar? Be 26. Placa of Death (Check only ona) Hospital: 1□ Yas 27 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth
Lanaural
2 Accident 28d. Dascribe how Injury occurred Certification: 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Op the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only 29d. Data signed (Month, Day, Year) Itam 23a) (Type, Print)

Registrar

DHMH 16 Rev 6/95

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item 27 is marked other than "natural", or items 23s or 28s-4 show other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter deeth 1 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23. any Injury or other traumatic event, the Mendest Examine must

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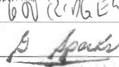
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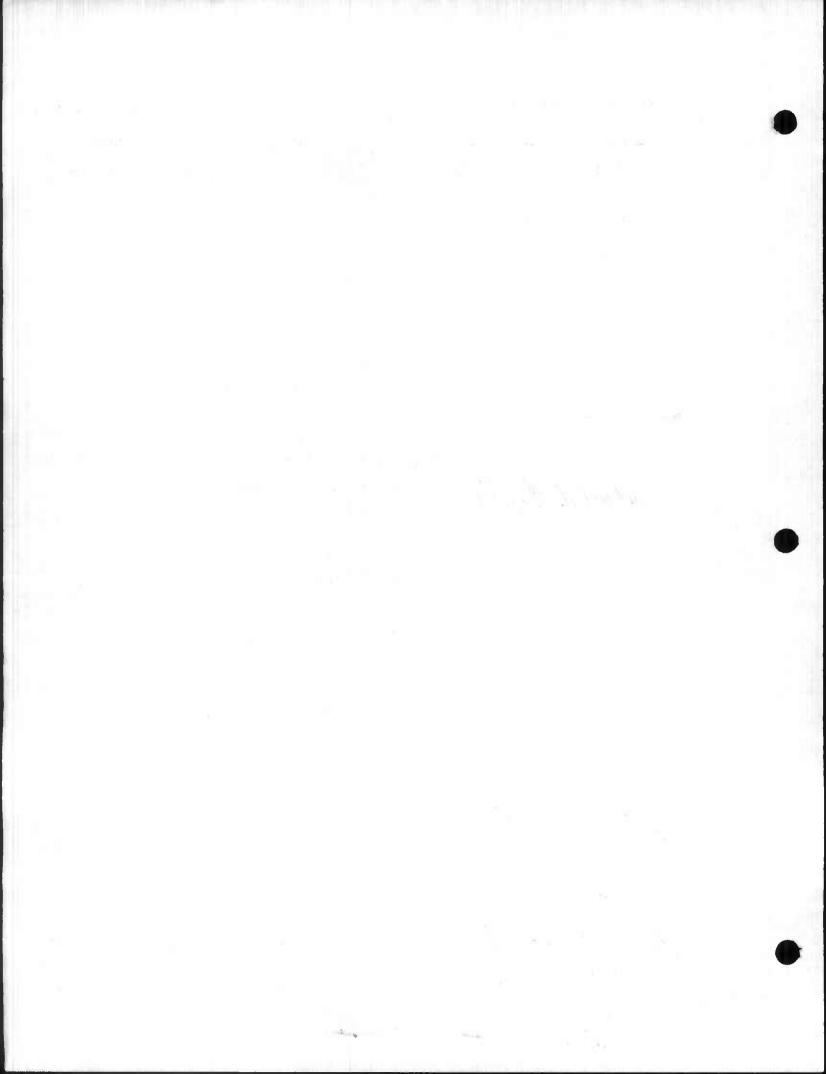
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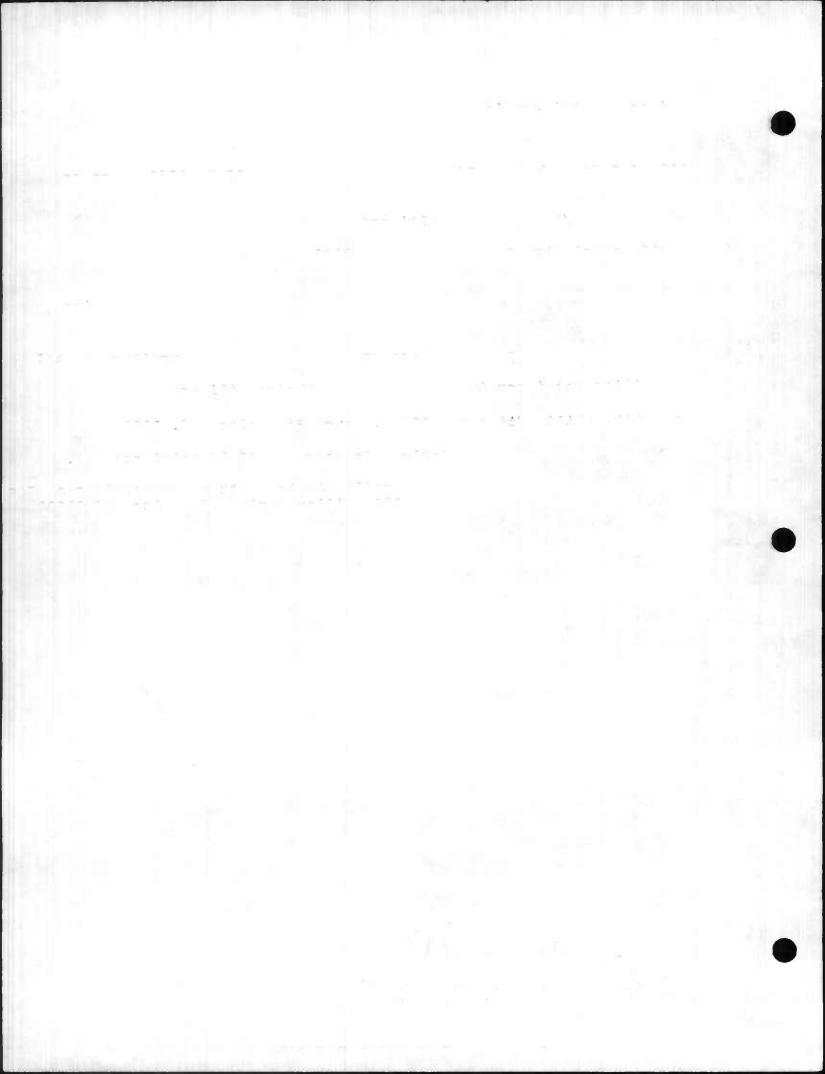




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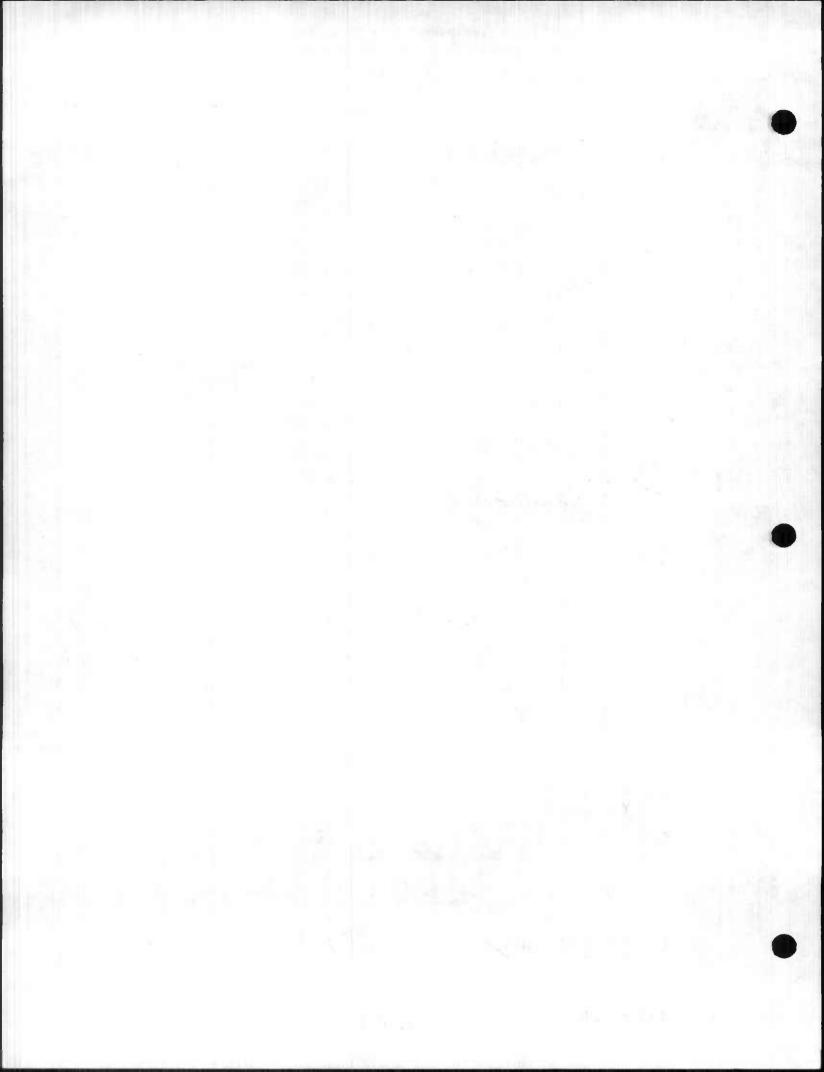
| 1. Decedent's N | lame (First, Middle | | te of Mary | | | | | 2. Date of C | Death | | 3. Tima of Death |
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| 4s Facility Nan | ne (If not institution | | | | | 4b. City, Tox | wn, or Loca | ation of De | ath 4c. Co | unty of De | eath |
| F. Caslal Cana | | | ical Cen | | If Under 1 Year | | timo | | | N/A | |
| 5. Social Securi 215-80 | | 6. Sex | | yrs. last birthday) Yrs. | Months Days | | Min. | | Day, Year) | | irthplace (State or Foreig Country) |
| Usual Residence | e of Decedent | | 30 | | | | | 02 1 | 4 1963 | 3 (| Greece |
| 10a. State | 10b. County | | 100 | c. City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| Md | N/ | /A | | Baltim | 7 | | | | | | 1 Yes 2 No |
| 10e. Street and 426 | Bonsal | Stree | + | | 10f, Zip Code | 224 | | | 10g. Citizen | | |
| 11. Marital State | | | Decedent Ever | in U.S. 13. | Was Decedent of | | nin? (Spec | ify Yes or I | lo- 14. | US Z | A nerican Indian, |
| 1 Never N | Married 2 Married 4 Divorced | ied 1 Arm | ed Forces? Yes 2 No es, Give or or Dates: | | Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🗷 No | | , Puerto R | ican, etc.) | | Black, Wh | |
| /6 | 15. Decedent specify only highes | t's Education | lated) | 16a. Dece | dent's Usual Occu | pation | of working | ~ | 16b. Kind | of Busines | |
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| | lios Ha | | orgiou | | | | | | | mame/ | |
| | a Name/Relations | | | 19b. Maili | ing Address (Stree | | | Filij Route Num | - | own, State. | , Zip Code) |
| Tsamb | ika Phi | lips/ | sister | 724 | S. Ponc | a St | . Ba | lto. | Md. 2 | 1224 | 1 |
| 20a. Method of | | о. Пр.————— | THE RESERVE OF THE PARTY OF THE | Ob. Place of Dispo | osition (Name of matory or other pla | ace) | | Date | | | or Town, State |
| | 2 ☐ Cremation on 5 ☐ Other (S) | | from State | Oaklaw | n Cemet | ery | 02 | 2 10 | Balti | more | Md. |
| shock, or | er the disease, or heart failure. List | con plications only one cause | that caused the e on each line. | death. Do not ent | 134 Will ter the mode of dy | low S | Sprir cardiac or | respiratory | errest, | to, | Approximata Interval Batween Onset and Death |
| Immediate Cau disease or con- resulting in dea Sequentially lis if any, leading to cause. Enter to Cause (Diseas | t conditions, or immediate inderlying | a. O | CCLUSIVE Due DEEP VEI Due | E PULMON, to (or as a consec N THROMB | ARY THRO! quence of): BOSIS COM quence of): | MBOEMB | OLI | respiratory | errest. | and Residen | Approximata Interval Batween |
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| Immediate Caudisease or con- resulting in dee Sequentially lis if any, leading it cause. Enter It Cause (Disease that initiated ever resulting in dea Part II. Other elements of the cause of the caus | se (Finel dition th) It conditions, o immediate noderlying entriping entrip | a. C b. C c. C d. C Hospital: | Due | E PULMON. to (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): BOSIS COM quence of): quence of): quence of): quence of): quence of): | MBOEMB PLICAT iven in Part I. | OLI TING of Death rsing Home | INJUR 23b. Di 1[24a. Wa per 10] (Check only e 5 □ Re 8d. Describ | d tobacco used tob | OWER Ontribu No 3 24b Other (Sp. | Approximate Interval Batween Onset and Death Death Onset and Death Death Onset and Death |
| Immediate Caudisease or concessiting in dee Sequentially list if any, leading it cause. Enter U Cause (Disease that initiated ev resulting in dea 25. Was case nexaminer? 1 [XYes 22. | se (Finel dition th) It conditions, o immediate inderlying sor injury ents th) Last prificant conditions the conditions of the condition | d. Hospital: Hospital: 28a. 1- not be 28e. 28e. | Due Due Due Due Due Due Due Due | PULMON. to (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): SOSIS COM quence of): quence of | MBOEMB PLICAT iven in Part I. 26. Place ther: 4 Nur ury at ork? Yes 2 Yes | OLI CING OF Death rsing Home | 23b. Di 1[24a. Wa pei (Check only STRUC | d tobacco used as an autopsy formed? Yes 2 N Yes 3 N Yes 4 N Yes 4 N Yes 4 N Yes 5 N | OWER Sontribu 24b Other (Specured POTOR | Approximate Interval Batween Onset and Death Onset Interval Batween Interval Batween Interval Batween Interval Batween Interval Bat |
| Immediate Caudisease or con- resulting in dee Sequentially lis- if any, leading it cause. Enter U Cause (Disease that initiated ev- resulting in dea Part II. Other el- 1 | se (Finel dition th) It conditions, o immediate noderlying e or injury ents th) Last prifficant condition gnifficant condition 5 Pending investig to Could reference to Could refere | d. Hospital: Galation 1- g Physician: T Examiner: On 1 | Due Due Due To death but no To death but no To death but no Place of Injury (Month, Day Yea 19 2000 Place of Injury building, etc. (S) | PULMON. to (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): BOSIS COM quence of): quence of) | MBOEMB IPLICAT iven in Part I. 26. Place ther: 4 Nurury at ork? Yes 2 1 | OLI CING TING Tring Home | 23b. Di 1[24a. Wa per 10 (Check only e 5 □ Re 8d. Describ STRUC 8f. Location City or 7 ONCA | d tobacco used to tobacco used | OWER Contribution Contributi | Approximate Interval Batween Onset and Death Death Onset and Death Death Onset and Death Death Death Death Death Death Death D |
| Immediate Caudisease or contresulting in dee Sequentially list if any, leading it cause. Enter to Cause (Disease that initiated ever resulting in dea 25. Was case in examine? 1 Natural 2 Accider 3 Suicide 4 Homici | se (Finel dition th) It conditions, o immediate noderlying e or injury ents th) Last prifficant condition gnifficant condition 5 Pending investig to Could reference to Could refere | d | Due | PULMON. to (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): BOSIS COM quence of): quence of) | MBOEMB IPLICAT iven in Part I. 26. Place ther: 4 Nurury at ork? Yes 2 1 | OLI CING TING Tring Home | 23b. Di 1[24a. Wa per 10 (Check only e 5 □ Re 8d. Describ STRUC 8f. Location City or 7 ONCA | d tobacco used Y OF LO d tobacco used Yes 201 as an autopsy formed? Yes 2 N Yone) sidence 6 e how injury or K BY M (Street and N own, State) ST., But e cause(s) en, date and pla | OWER Contribution 24b OTOR ALTO d manner ace, and di | Approximate Interval Batween Onset and Death Onset of death Onset of death Onset of Death Onset on Dea |
| Immediate Caudisease or contresulting in dee Sequentially list if any, leading it cause. Enter to Cause (Disease that initiated ever resulting in dea 25. Was case in examine? 1 Natural 2 Accider 3 Suicide 4 Homici | se (Finel dition th) It conditions, o immediate noderlying a or injury ents th) Last prifficant conditions to medical the conditions the co | d | Due | PULMON. to (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): SOSIS COM quence of): quence of | iven in Part I. 26. Place ther: 4 Nurury at ork? Yes 2) | of Death rsing Home rsing Home 28 d place, and | 23b. Di 1[24a. Wa per 10 (Check only e 5 □ Re 8d. Describ STRUC 8f. Location City or 7 ONCA | d tobacco used to tobacco used | OWER Contribution Contributi | Approximate Interval Batween Onset and Death Onset In O |
| Immediate Caudisease or com- resulting in dee Sequentially lis if any, leading it cause. Enter I Cause (Disease that initiated ev- resulting in dea Part II. Other elements of the cause | se (Finel dition th) It conditions, o immediate noderlying a or injury ents th) Last prifficant conditions to medical the conditions the co | d | Due | PULMON. Ito (or as a consect N THROMB to (or as a consect to (or as | ARY THRO! quence of): BOSIS COM quence of): quence of) | iven in Part I. 26. Place ther: 4 Nur very at ork? Yes 2 1 | of Death rsing Home | 23b. Di 10 24a. Wa per 25 Re 86 Describ STRUC 67 ONCA did due to the | d tobacco used as an autopsy formed? Yes 2 Note to the first of the f | OWER Contribution Contributi | Approximate Interval Batween Onset and Death Onset O |
| Immediate Caudisease or contresulting in dee Sequentially list if any, leading it cause. Enter U cause (Disease that initiated ev resulting in dea 25. Was case nexaminer? 1 \(\text{N} \text{ Ves} \) accides 227. Manner of D 1 \(\text{ Natural 2} \text{ Accides 4 \(\text{ Homicis 1} \) decides 4 \(\text{ Homicis 1} \) decides 29a. Certifier (Check only one) 25b. Segnature 1 | se (Finel dition th) It conditions, o immediate noderlying a or injury ents th) Last price of the medical condition of the | d | Due | E PULMON. Ito (or as a consect N THROMB to (or as a consect to (| ARY THRO! quence of): BOSIS COM quence of): quence of) | MBOEMB PLICAT PLICAT 26. Place ther: 4 Nurury at ork? Yes 2 1) ime, date and opinion, deet are number .C.M.E | of Death rsing Home | 23b. Di 10 24a. Wa per 25 Re 86 Describ STRUC 67 ONCA did due to the | d tobacco used as an autopsy formed? Yes 2 Note to the first of the f | OWER Contribution Contributi | Approximate Interval Batween Onset and Death Onset O |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** PRESTON DAVID HUTCHINSON 2000 10:20 PM feb. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Harford Fallston 3314 Charles Street If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Mar. 27, 1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs 215-34-9238 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e 28a-f show instiffed at 1 Yes 2 No Directo Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n 21087 U.S.A. 3314 Chsrles Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Minister Religion 12 yrs 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be B Evelyn H. Gartside Preston A. Hutchinson 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Charles Street Fallston.MD.21047 Jo-Ann Hutchinson 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition. 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Highview Memorial Grdns. 2/7/2000 Fallston, Maryland21047 ure of Funeral S 22. Neme and Address of Facility Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 23a. Pert1. Enter the disease, ov complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immedieta Cause (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner lashens The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and crainana P.O. Box 68760. the for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? signed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, p Be Completed 24b. Were autopsy findings sveilable prior to page 2 should 24a. Was en eutopsy completion of cause of death? 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate I or Attending Physician: Taffer death.

Director: After this certifica director, 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edicai Certification: To 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State TT 2000 Registrar



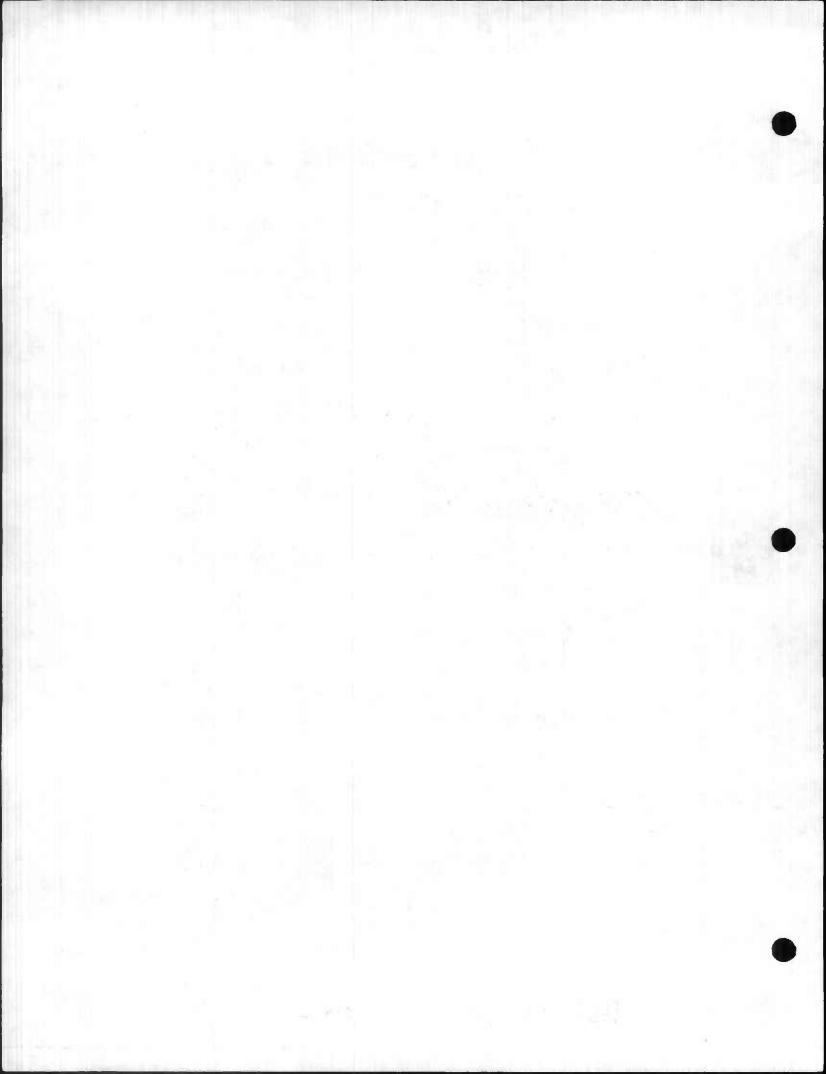
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 02 **Physician** WILLIAM TILGHMAN TSAAC 09 2000 9:16 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 N. BELLE GROVE ROAD CATONSVILLE BALTIMORE 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, **Funeral** Days 1 € M 2 □ F Months Hours Yrs. 216-10-0434 95 11-15-1904 **Director** Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rem 27 is marked other than "natural", or Nama 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at MD BALTIMORE CATONSVILLE 1□ Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 3 N. BELLE GROVE ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 ahould be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic avant, the Medical Emerican once. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry SALES Elementary/Secondary (0-12) College (1-4or 5+) LANE BRYANT RETAIL STORE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TILGHMAN ISAAC JULIA ARNOLD t9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE DOROTHY SAVAGE ISAAC 3 N. BELLE GROVE ROAD. CATONSVILLE, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 02-10 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 2000 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 (some) 23a; Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical 2° to anoxic encephalopathy Examiner Due to (or as a consequence of): Examiner 20110 attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated execute.) Due to (or as a consequence of): P.O. Box 68760 **Physician/Medical** that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 TYes 202 No 1 TYes 2E No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

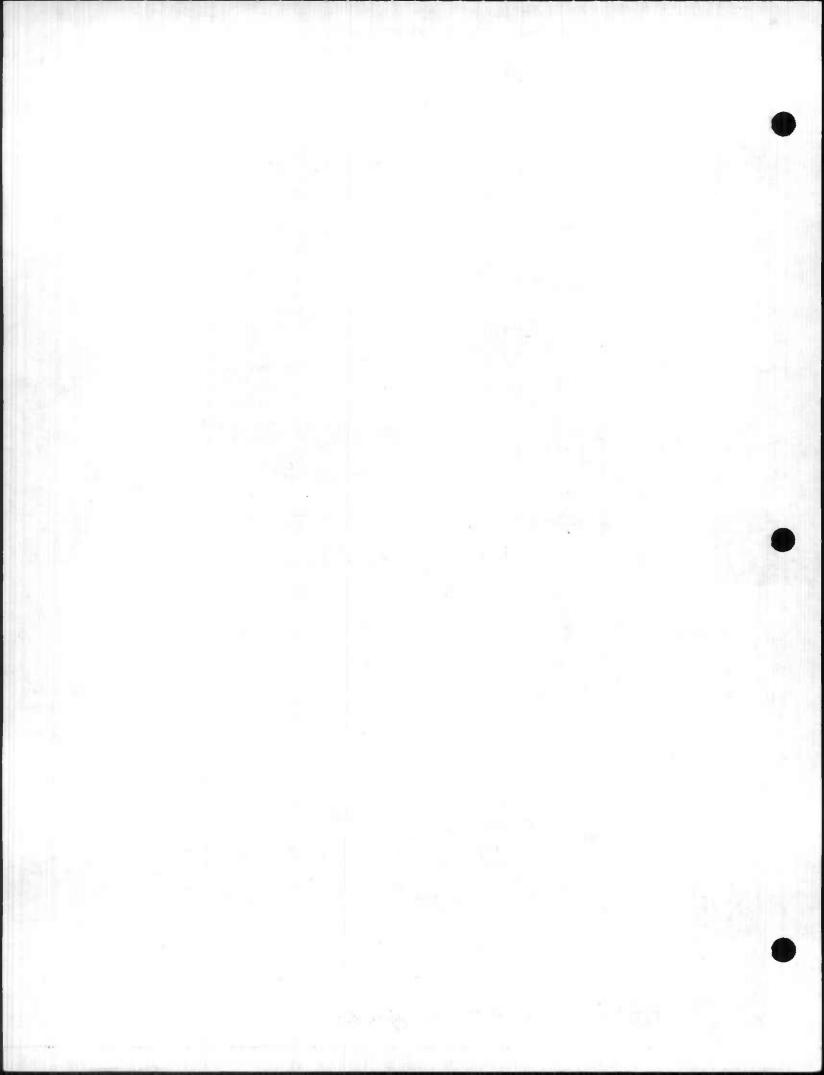
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 044243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOK IV 1120 N. ROLLING ROAD, BALTIMORE, MD WILLIAM J. M.D. 21228 31. Date filed (Month, Day, FEB 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 04233

| TYF | ONE C. | JOHNSON | | Ce | rtificate of | Death | | Re | eg. No. | J | 4233 |
|----------------------------|---|---|--|-----------------|-------------------------------------|----------------|-------------------|-------------------------------|------------------|--------------|--|
| | | 1. Decedent's Nama (First, Middle, L | ast) | | | | 2 | . Date of Deat | h | | 3. Time of Death |
| | Physician | Tyrone C. | Johnson, | Jr. | | | | Month FEB. | 8, 2000 | Year) | 3:03 AM |
| | /Medical Examiner | 4a Facility Name (If not institution, g | ve street and number) | | | 4b. City, To | wn, or Loca | tion of Death | 4c. County | | J 3.03 A1 |
| | | 3900 FLOWERTO | N ROAD | | | BAL | TIMOR | Œ | | NA | |
| | Funeral | | Sex 7. Age (In yrs. | | Months Days | | 24 Hrs. 8 Min. | Date of Birth (Month, Day, | Year) | 9. Birthp | Nace (State or Foreign |
| | Director | | ₹X ^{M 2□ F} 23 | Yrs. | | | | 06-26- | | | MD |
| 3 | | Usuel Rasidenca of Decedent 10a. Stete 10b. County | 10c. Cit | y, Town or Le | ocation | | | | | 1 | 0d. Inside City Limits |
| Anna | or and | MD NA | | | | | | | | | X□ Yes 2□ No |
| 9 | or 28s-f s be notified Director | 10e. Street and Number | y Bg | ltimo | 10f. Zip Code | | | 10 | Og. Citizen of 1 | What Cour | ntrv? |
| hospital of div deep | 0 0 0 | 4017 Colborne | Road | | 21229 | 2 | | | | | , |
| 400 | ar, or hame 234 Example must | 11. Meritel Stetus | 12. Wes Decedent Ever in U | S. 13. | Wes Decedent of If Yes, specify Cut | | gin? (Speci | fy Yes or No- | USA 14. Rad | e - Americ | an Indian, |
| - 3 | 44 F | Nevar Married 2 Merried | Armed Forces? 1 ☐ Yes 2 🔀 No | | | | | can, etc.) | | ck, White, | |
| 02 | b F. | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 Î No | Specify: | | | Specif | Bla | ck |
| 5-0020 | tal hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director | 15. Decedent's E | ducation | 16a. Dece | dent's Usual Occu | pation | t of working | | 16b. Kind of B | | |
| 2 | | Elementery/Secondary (0-12) 12th Grade | Cotlege (1-4or 5+) | life. | DO NOT use retire | ed) | o working | | | | y of MD. |
| d 2121 | Co | | NA | Fu] | ll-Time | | | | Medic | | ystem |
| Du a | H doth | 17. Father's Neme (First, Middle, Las | | | | 18. Mothe | er's Name (| First, Middle, N | Maiden Surnan | ne) | |
| arylan | To To | | Johnson, Sr | | | | ricia | | Col | - | |
| - C | 4 9 9 | 19e. Informant's Neme/Relationship | | | ing Address (Stree | | | | | | 21227 |
| e, 5 | Health m 27 ther | Patricia C | ole | 401/ | Colbor | ene R | oad I | Baltim Date | ore, M | aryl | and |
| mor | P F P | 1 🗷 Burial 2 □ Cramation 3 | Removel from State | emetery, cre | matory or other pla | 2C8) | t | Date | | | |
| בָּיב בּיב | tent | 4 Donation 5 Other (Spec | - V | oshel | 1 Mem. | Gard | ens (| 2-14- | | | alk,MD |
| Balt | Department of Important: If is any Injury or street. | 21. Signature of Funerel Service Lice | nsee | | | | | | | | nd 21202 |
| | 02.0 | Teren Co | a besta | | M.C.Mar | | | | | Ave | nue |
| | | 23a. Vert1. Enter the disease, or conshock, or heart feilura. List unit | one cause on each line | Do not en | ter the mode of dy | ing, such as | cardiac or | respiratory em | est, | | Approximate Interval Between Onset and Death |
| | hysician /Medical | Immediate Cours /Final | n/l | | |) | | | | 1 | Oriset and Death |
| | xaminer | Immediate Cause (Final disaasa or condition resulting in death) | NULTIPLE | GUI | USHOT W | lound. | S | | 2 | 1 | 00 =1 |
| | | | Due to (o | r as a conse | quence of): | | | | | 1 | |
| 3 | physician and is the bunal-transit | | b | | | | | | | | |
| | physician and s the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | ras a conse | quence of): | | | | | 1 | |
| 68760, | sicia burn | Cause (Disease or injury that initiated events | C. Due to fo | | | | | | | | |
| r 68760, | ing phy e as the | rasulting in death) Lest | Due to (o | r es a consec | quence or): | | | | | | |
| | | | d | | | | | | | - 1 | |
| Records, P.O. Box | been signed by the attendi should be detached for use leted by Physician/ | Part ti. Other aignificant conditions | contributing to death but not res | ulting in the u | Inderlying cause a | iven in Part I | | 23h Did to | hacen usa en | untribute to | o the cause of death? |
| P.O. | by th | | out in but ing to doubt but inct income | oning in alo o | moonying occase y | | • | 1 Y | 1 | | bebty 4 □ Unknown |
| The state | bede e de | | | | | | | | 7_110 | | |
| Division of Vital Records, | cate has been signed, page 2 should be d | | | | | | | 24a. Was a | | 24b. W | ere autopsy findings |
| 0 3 | s bee | | | | | | | perform | med / | co | mpletion of cause death? |
| E E | e has age 2 | | | | | | | 102 Ye | s 2 No | | Yes 2□ No |
| ta la | ertificat sctor, p | 25. Was case referred to medical | | | | 26 Place | of Death / | Check only on | | ., | 3100 22310 |
| > 2 | his cert if direct | examiner? XXYes 2 No | Hospital: | FB/Outpatie | nt 3 DOA | thom | | 5 ☐ Reside | | ner (Snecif | W AT CCENE |
| O | oral C | 27. Manner of Death | 28a. Dete of Injury Trust (Month, Day Year) | 28b. Time o | F 4 | | 7 | d. Describe ho | | | MAT SCENE |
| 0 | e fun | 1 Natural 5 Pending 2 Accident investigation | | 2:55 | | Yes 2 1 | No | SUR | SECT SH | OT | |
| VIS Affe | octo by th | 3□ Suicide 6 □ Could not determined | 28e. Plece of Injury - At he | ome, farm, st | | (found) |) 28 | - | | | al Route Number, |
| | ins after death. a) Director: After to led in by the funeral Certification: | 4 perionicios | building, etc. (Specifi | STRE | ET | | | | ALTIMONE | | |
| people | within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com | | hyaician: To the best of my kno | wledge, deat | h occurred at the t | | | d due to the ca | ause(s) and m | anner as s | tated. |
| 2 | in 24 hours the Fune pletely fil | one) 22 Madical Exa | miner: On the basis of examina end menner steted. | non and/or in | ivestigation, in my | opinion, dea | to occurred | at the time, di | are and place, | and due to |) the cause(s) |
| Tot | To To To | 29b. Signatura and titla of certifier | 1 11 | | 29c. Licen | se number | | 2 | 9d. Date signe | ed (Month, | Day, Year) |
| i | IV/ | 1 | M. It | | 0. | C.M.E | | | FEB. | 8, | 2000 |
| 1 | 11/6 | 30. Neme and address of person who | | | | - 14 | | | | | |
| | 1 | JACK MITIN | 15, mil). 11 | 1 Penr | n Street, | Balt | imore | , Mary] | and 21 | 201 | |
| | State | 31. Dete filed (Month, Day, Year) | 32. Registrar's Signa | tuse | 1 | | | | | | |
| | Registrar | FEB 1 1 2000 | Hard 1 | 1. 19 | paiks | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev **Physician** JAMES ROBERT JONES 12:47 /21 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2035 W. LANUALE STREET BAHIMORE If Under 24 Hrs. B. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 4□ M 2□ F If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 58 Director Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inaide City Limits ahoe BAHIMORE 1 Tes 2 No Mary mo ms 23a or 28a-f Directo 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 3627 YOLANDA 21218 USB Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use gatired) 16b. Kind of Business/Industry Hygiene. Corportron ALUNDEI Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if them 27 is marked other tha any injury or other traumatic achier tha 90.06. TRUCK DIRIVER grack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be SAVAL E. JERENS JOSHUA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. LANUALE ST 2035 BOHAMOR, Ald BECCA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State AVBUTUS, Maryporces 4 □ Donation 5 □ Other (Specify) BUTUS Memorial 22. Name and Address of Facility CHATMAN - HAMIT
5240 PEISTS Website Address of Facility 21. Signature of Funeral Service Licenses Funtral Hop 240 REISTENSTUN MINO Tele take Bp/ horore Marylows 31011 23a. Part7. Enter the massar, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): Physician/Medical Examiner physicien end the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): signed by the e Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 N Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopay findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 8 26. Placa of Deeth (Check only one) Sister's Other: 4 Nursing Home 5 Residence 6 MOther (Specify) PLS dence 1 Yes ≥ No 1 Inpatient 2 ER/Outpetient 3 DOA this. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? be Hospital or Attending P n 24 hours after death.

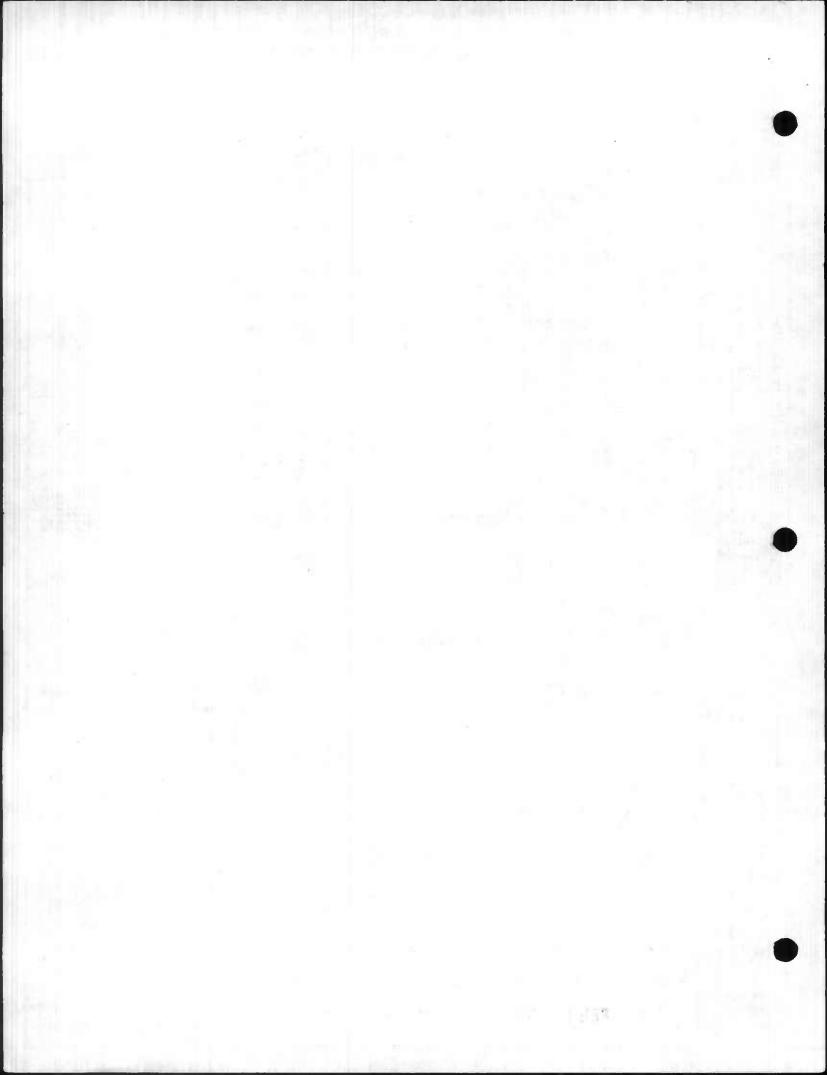
Permenal Director: After the plately filled in by the funeral 1 X Natural 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical Vithin 24 hours To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Nobert Tao-Ping Chow February 9, 2000 134851 30. Name and address of person who completed cause of death (flor 23a) (Type, Print)

Rolling ADRE AVE Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Depera FEB 11 2000

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Physician 3:40 AM FEBRUARY 07, 2000 Samuel Lee Johnson /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosp. Baltimore Union Memorial If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 € M 2 F Yrs. Director 212-36-5799 Usual Residence of Decedent S.C 10a. Steta 10b County 10c. City, Town or Location 10d. Inside City Limits show ¥Exres 2□ No Director 28a-f MD Baltimore NA The 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò must be 238 Funeral 5316 Lynview Ave 21215 U.S.A.

14. Race - American Indian, Name 2 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes XXNo
If Yas, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Stetus Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Merried b 21215-0020 1 ☐ Yes 2 ☒ No Specify: p 3 Widowed 4 Divorced natural Black Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. Elementery/Secondery (0-12) College (1-4or 5+) Exterminator

18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Home Paramount Ith and Mental Hygis

7 is marked other
traumatic event. Baltimore, Maryland Be Elliott Johnson
19e. Informent's Neme/Reletionship (Type, Pnint) Annie Mae Johnson

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Vernetta Armstrong-Daughter 4222 Crawford Ave, Baltimore Md
20e. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other piece)

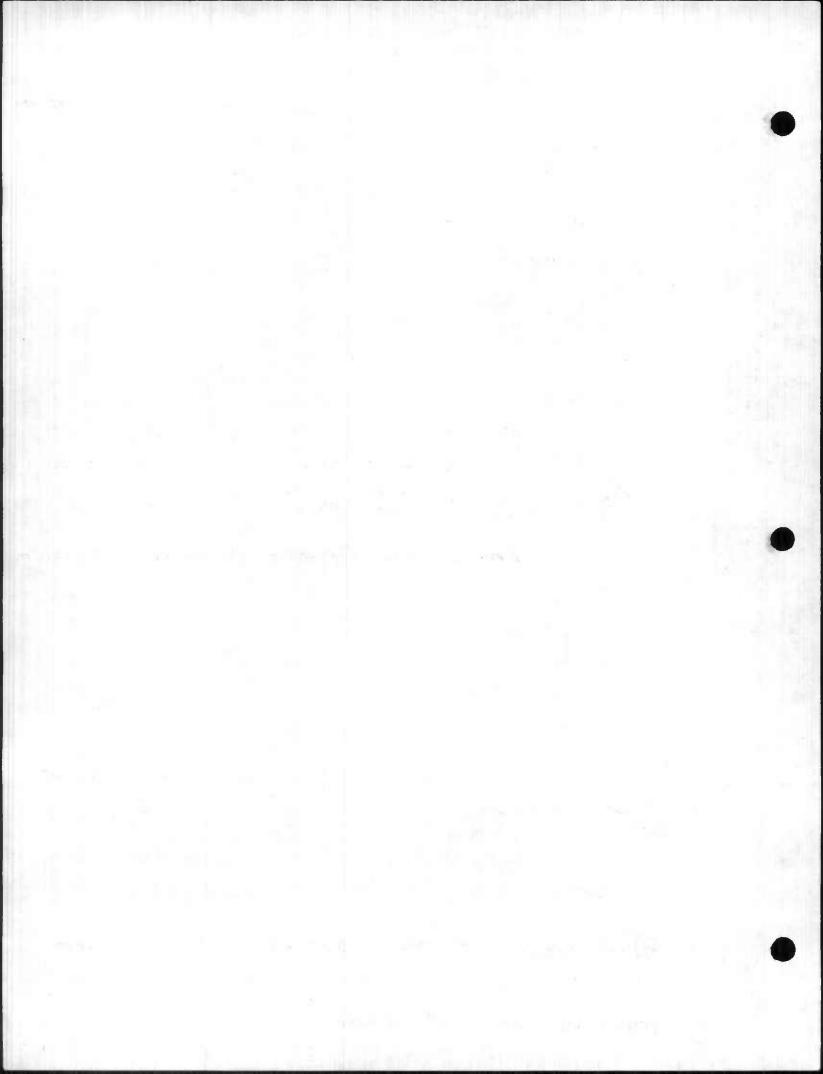
20c. Location - City or commerce of the commerce of the cemetery, cremetory or other piece) 21215 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Zion Cemetery

22. Neme and Address of Fecility 2/11/2000 Baltimore, Md Mt. 21. Signeture of Funeral Service Licensee March F/H West 23a. Flart. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

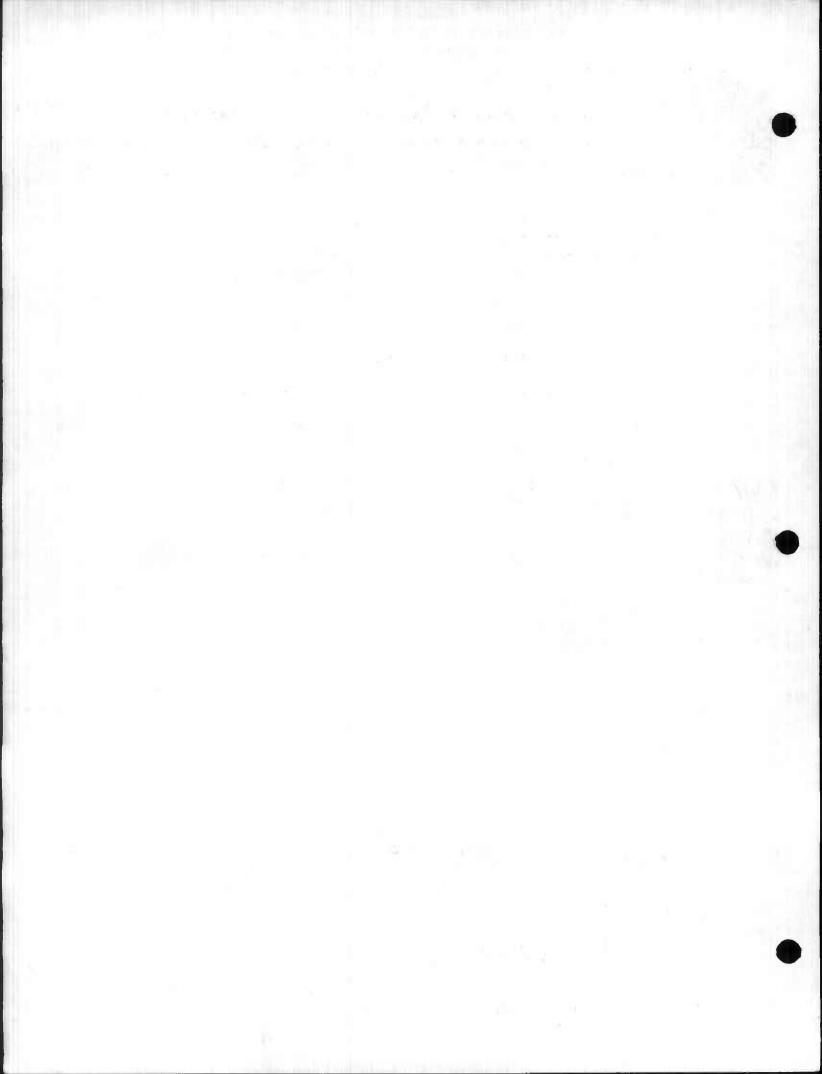
Approximate Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting In daath) /Medical CARCINOMA DF LUNG (ELL 6 MONTHS Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical eug. Due to (or es a consequence of): 88 980 Pert II. Other algorificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate has 1 Yes 2 No 1 Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2□No Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding invastigation 1 Maturel death. 1 TYes 2 □ No 2 Accident after death Director: \$ 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital 24 hours a Funeral 29a. Certifier 1 Conflitying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and menner steted. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY 07, 2000 lammana, PHYSICIAN 147123 30. Name and address of parson who complated causa of death (Item 23a) (Typa, Print) UNION MEM. HOSP. 201 E. UNIV. PKNY, BALTIMORE PUTHWITHNA, JUSEPH 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar books

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Amende | d I | I tem#10e perFH G780 2/11/2000 EW Certificate of Death | | Reg. No. | |
|---|-------------------|--|---|--|--|
| Physici /Medi | | Toxas Richard Rosus | 2. Date of E Month | Day Year | 3. Time of Death |
| Examir | | | Town, or Location of De | ath 4c. County of Dea | th |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under | S CONTROL NE er 24 Hrs. 8. Date of E | Birth 9. Bir | tholace (State or Foreign |
| Director | | 213-30-6732 15 M 2□ F 67 Yrs. Months Days Hours Usual Residence of Decedent | Min. Sept 7 | Pay, Year 9. Bir | thplace (State or Foreign ountry) MD |
| show | | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| 28a-1 s notified | Director | MD Baltimore Baltimore | | | 1 Yes 2 No |
| Nems 23s or 28s-f shorter man be notified at | | 10e. Street and Number 112 Minebank LA. Donald R. Keene 21227 | | 10g. Citizen of What Co | ountry? |
| Nems : | Funeral | 11. Marital Status 12. Was Decedent Ever In U.S. Amed Forces? 13. Was Decedent of Hispanic C | Origin? (Specify Yes or Nean, Puerto Rican, etc.) | No- 14. Raca - Ame Black, Whit | |
| af, or l | by F | 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specifi Year or Dates: | | Specify: | white |
| dical | Completed | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during me | ost of working | 16b. Kind of Business | Andustry |
| Dan Da Ma | dmo | Elementary/Secondary (0-12) College (1-4or 5+) | | | |
| other vent, | Be C | 17. Father's Name (First, Middle, Last) plumber 18. Mot | her's Name (First, Midd | plumbin le, <i>Maid</i> en Su <i>ma</i> me) | g |
| marks marks | 2 | John Wesley Keene | Madeline L. | Phillips_ | |
| 27 is m r traum | | 19e. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street | | | Zip Code) |
| If Item or othe | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Placa of Disposition (Name of camelery, crematory or other place) | Date | 20c. Location - City or | Town, State |
| #5 | | 4 X Donetion 5 Other (Specify) | | | |
| seny Inju | | 21. Schahure of Funeral Service Licensee Ronald S, Wade, Director State Anatomy | | W. Baltimore | Street |
| | 1 | Baltimore, MD Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such a hock, or heart failure. List only one cause on each line. | 21201 as cardiac or respiratory | arrest, | Approximate Intervel Between |
| sician ledical | | | ./ | | Onset and Death |
| aminer | | Immediate Ceuse (Finel disease or condition resulting in death) a. Due to (or as a consequence of): | HORI | 2 | |
| sit | luer | bue to (or as a consequence on): | | | |
| physician and the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | | | |
| hysicia the bur | | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | _ | |
| CD 66 | Physician/Medical | d | | | |
| e attendir | iclar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Per | 235 DI | d tobacco use contribute | to the course of death ? |
| ed by the datached | | The second secon | | Yes 2 No 3 P | and the second |
| 500 | d by | | 24a Wa | is an autopsy 24b. | Were autopsy findings |
| s been si 2 should I | Completed | | per | formed? | avallable prior to completion of cause of death? |
| paga 2 | Com | | 10 | Yes 2 No | 1 Yes 2 No |
| rector, pag | o Be | Hospital: | ce of Deeth (Check only | | |
| After this funeral di | - | 27. Manner of Death 28s. Date of Injury 28b. Time of 2sc. Injury at | | sidenca 6 Other (Spe how Injury occurred | cify) |
| or: Aft | catlo | 2 Accident investigation Poblic 24 4 M 1 Yes 2 | OPL | firth | TED |
| I Director: Afi d in by the fu | Certification | 4 Hamilton determined determined 256. Place of Injury / At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location | (Street and Number of Right) | Trai Houte Number, |
| To the Funeral Dire complataly filled in b | | 29a Carllying Phyaician: To the best of my knowledge, deeth occurred at the time, dete | and place, end due to the | o course(s) and mannages | mn Rykma |
| mplate | Medical | and manner stated | | | |
| 2 8 | | 29b. Signification and rate of countier | 7, | February | 1, 2000 |
| | | 30. Names and address of person who completed cause of death-(Hairr 20s) (Type/Print) | | maryk | n, Day, Year) 1, 2000 POR(2/229) LILE |
| | | E.P. WilliamSoNA 405 FReder | RIEK ROPE | 1 CATO AS | LILE |
| Stat Registra | ٠ | 31. Date filed (Month, Day, Year) FEB 11 2000 Server & Space | Kar | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0950 FEBRUARY 2000 Violet L. Kesler /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Mercy Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-8-1948 Birthplace (State or Foreign Country) **Funeral** Months 10 M 20 F Days Hours Min. 216-54-0031 51 Yrs Director Md Usuel Residence of Decedent the Meryland 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** rithen "natural", or items 23s or 28s-f ehorens in Medical Examinar must be notified at 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 4217 W. Rogers Avenue 21215 11 S A Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours effect and of Health and Mental Hygiene.
Int: If Hem 27 is marked other than "natural", or he iny or other traumfile event, me led. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Specify: Black 1 Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mercy Hospital Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12th grade years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Kane Mary Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zachery Kesler - Son Rogers Avenue Baltimore, Md 21215 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Department of Important: If any injury or page. 4 □ Donation 5 □ Other (Specify) Mt Zion Cemetery 2-11-00 Lansdown, Md 22. Name and Address of Fecility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Avenue Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that cau will the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Brenst /Medical tmmediate Cause (Final Carre disease or condition resulting in death) Examiner Examiner physician and the burlef-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 20 080 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? pege 2 1 ☐ Yes 2 ☐ No certificate 1 Yes director, 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 32 No Other: 4 Nursing Home 5 Residence Other (Specify) Medical Certification: To 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stele) filled in by 4 Homicide

or Attending Physicien: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. To the Mossital of with a four a of To the Funeral D

Baltimore, Maryland 21215-0020

State

Registrar

29b. Signature and title of certifie

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2-6-2000

D40854

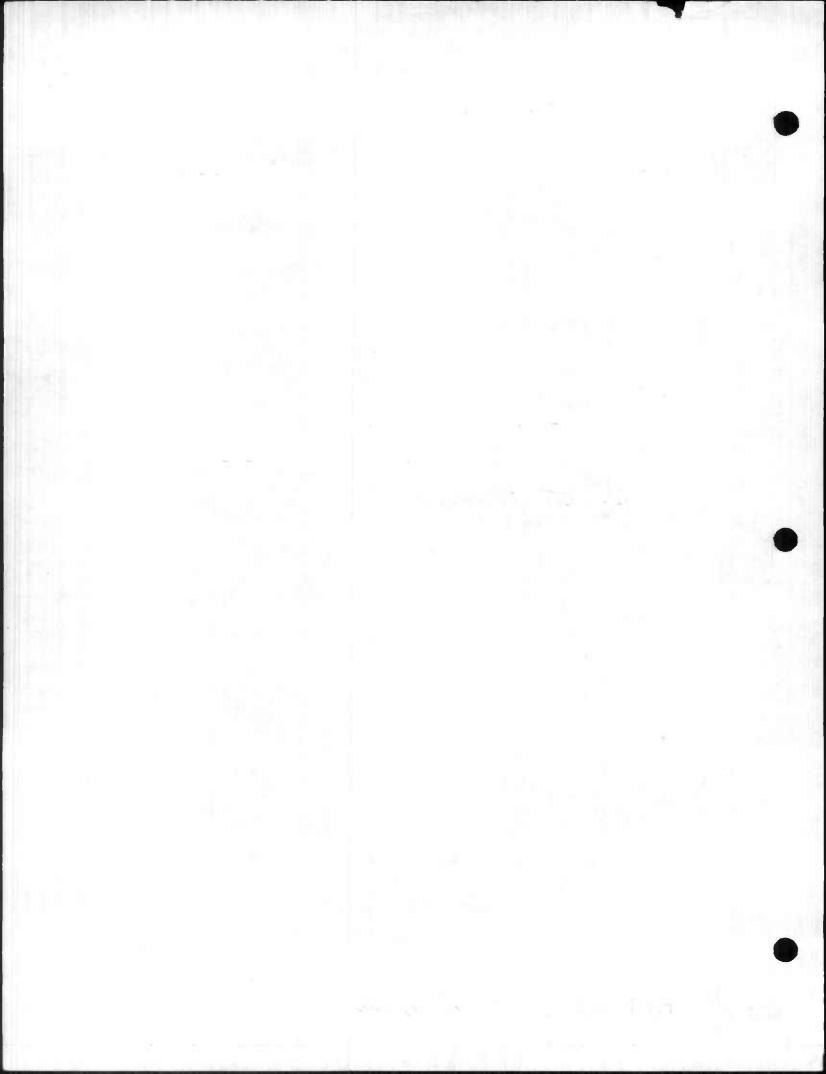
30. Name and address of person yeo completed cause of death (Item 23a) (Type, Print) Useber

Baltimer

29a. Certifier (Check only one)

> 301 St Paul Pl 32 Begistrar's Signature

M



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month - ebruary 9 auc - heath | 4c. County of Death JOSEPH KUYAWA 59 A.M 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) osedale If Under 24 Hrs. 8. Da Franklin Square Hospital 5. Social Security Number 6. Sex 7. Aga (In yrs. la. Cent Baltimore 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthplaca (Stata or Foraign Country) Months DOM 20 F Days Hours 215-01-7780 87 Feb 25 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Baltimore Essex 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 404 Frankin Ave. 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yas, Giva Yaar or Datas: 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Man Continental CanCo. 7th 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Michael Kuyawa Anna Fehn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Frank Kuyawa /brother 183 Bennett Road Baltimore MD 21221 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2/11/2000 Baltimore Md. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in death) Obstructive Pulmonary Disease Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 PYea 2 No 3 Probably 4 Unknown Hypertension 24a. Was an autopsy performed? 24b. Wara autopsy tindings eveilable prior to completion of cause ot death? Bradycardia, Pacemaker 1 🗆 Yas 2 DNo 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation 1 @Natural 1 TYas 2 No 2 Accident 6 Could not be detarmined 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

Examiner The lew requires that the deeth certificete be executed Completed by Physician/Medical certificate 8 Certification: To this After

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

288-1 2

b

Berns 23a

natural, or

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

altimore,

Important: If Item 27 is ony injury or other tra pdcs.

Physician /Medical

Examiner

Box 68760, P.O. Division of Vital Records, or Attanding Physician: within 24 hours after death. To the Funerel Director: A filled in by Hospital completely \$

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Nona Novello

Registrar

31. Data filed (Month, Day, Year) 1 1 2000 FEB

9000 Franklin Square 32 Registrar's Signatura

ress of person who completed ceusa of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dafe signed (Month, Day, Year)

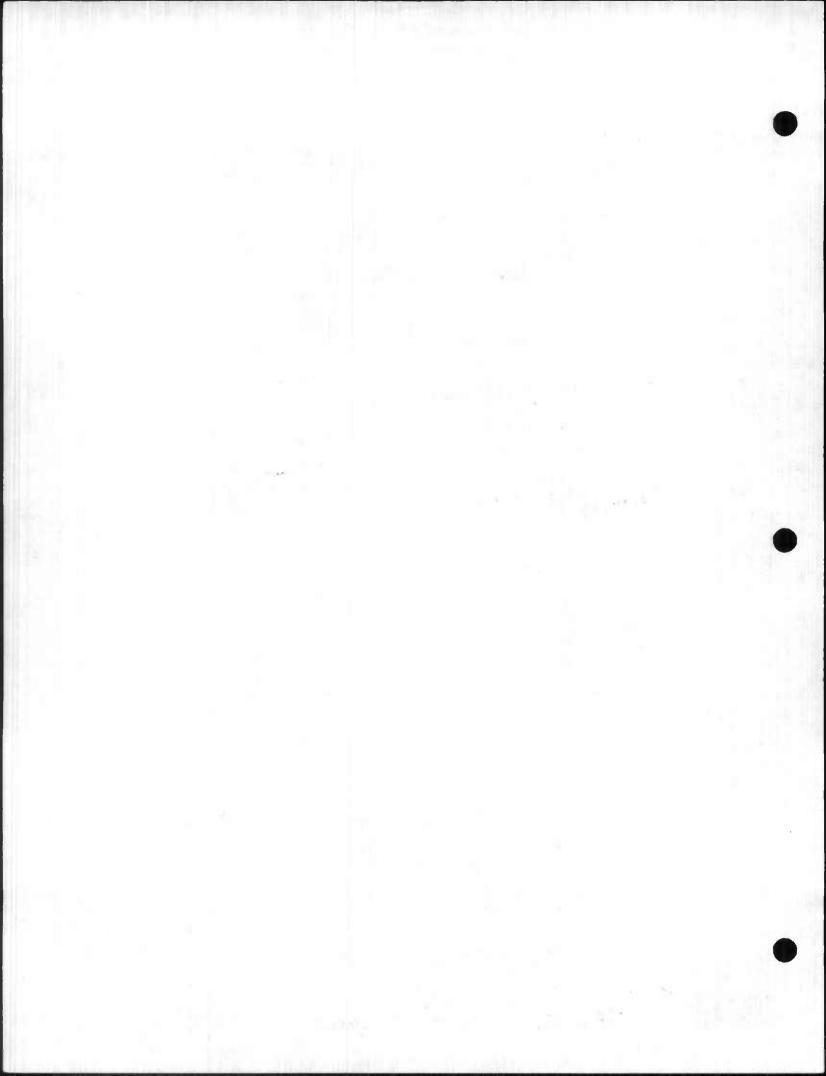
Drive Baltimore, Mp 21237

DHMH 16 Rev 6/95

service the many to the service

State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Name (First, Middle, Last) | ificate of Death | Reg. No. | 3. Tima of Death |
|---|---|--|---|--|
| Physician | | | Month Day | Year |
| /Medical | Lilly Kegley | 4h Cib. Town or l | February 9, 20 | |
| Examiner | 4a Facility Name (If not institution, give street and number) 911 D Royal Street | 4b. City, Town, or Annapol | | ounty of Death nne Arundel |
| Funeral Director | 579-58-6503 12 M 21X 54 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 6. Date of Birth (Month, Day, Year) Jan. 6, 1946 | 9. Birthplace (Stata or Foreign Country) Washington, DC |
| Mane Mane | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local | ation | | 10d. Inside City Limits |
| or 28a-f st be notified Director | MD Anne Arundel Annapol: | | | 1 No Yes 2 No |
| | 10e. Street and Number 911 D Royal Street | 101. Zip Code 21401 | | n of What Country? JSA |
| -0020 hours after death turel', or herre 23 al Examiner must of by Funeral | 1 Never Married 2 Married 1 Yes 2 No | as Decedent of Hispanic Origin? (S fes, specify Cuban, Mexican, Puert Yes 2 \$\frac{12}{3}\$ No Specify: | | . Race - American Indian, Bleck, White, etc. pecify: White |
| 1215- | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 16a. Decede (Give ki life. DC Homema | nt's Usual Occupation and of work done during most of wor NOT use retired) | king | of Business/Industry Home |
| ind 2 tel Hyge d other event, it | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Maiden Si | |
| ylai Menta M | Stanley Everett Burroughs | Viola | Lee Beavers | |
| Mar da 2 sh the and The mark trauman | | Address (Street and Number or Fluornwallis Cove, | | |
| of Heal | 20a. Method of Disposition 20b. Place of Disposition | ion (Name of | Deta 20c. Loca | tion - City or Town, Stata |
| Baltimore, semit. Pages 1 a bepartment of Hes mportant: If Nem my injury or othe most. | 1 Ky burial 2 Li Cremation 3 Li Hemoval from State | oln Cemetery | 02/14 2000 Bren | ntwood, MD |
| Ball Depart Import any in | Ha Ha | Name and Address of Facility rdesty Funeral Home, Ridgely Avenue, Ann | | 01 |
| Physician /Medical Examiner | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence) | | | Interval Between Onset and Death |
| BOX 68760, seth certificate be executed attending physician and for use as the burial-transit slaryMedical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | ence of): | | |
| . 5 . 5 | Part II. Other significant conditions contributing to death but not resulting in the und | erlying cause given in Part I. | 23b. Did tobacco us | na contribute to the cause of death? |
| - 2 22 - | | | 1 Yes 2 | No 3☐ Probably 4☐ Unknown |
| law law | | | 24a. Was an autops; performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| - F 44 0 | | | 1 ☐ Yes 2 🔀 | No. 1 Yas 2 No |
| Of VItal I Physicien: The this certificate ral director, per | 25. Was case referred to medical anaminer? Hospital: | Other | th (Check only one) | |
| on of fing Phys. After this funeral di | 1 Meanner of Death 27. Manner of Death 1 Meanural 5 Pending 2 Accident investigation 1 Pospital. 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | 3 DOA 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No | ome 5 Residence 6 l 28d. Describe how injury | |
| 2 84 5 E | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) | t, factory, office | 28f. Location (Street and City or Town, State) | Number or Rural Route Number, |
| tospi 4 hour uner losi | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant and manner stated. | occurred at the time, date and placa stigation, in my opinion, death occu | , and due to the cause(s) arred et the time, date and p | nd manner as stated. lace, and due to the ceuse(s) |
| To the I within 2 To the complet | 29b. Signature and title of certifier Deputy | 29c. License number | | signed (Month, Day, Year) |
| | William F. (Ass mo | 1) 060 | 21 | 10/00 |
| <u>Q</u> | 30. Name and address of person who completed cause of death (from 23a) (Type, Pr | 695 K | America | 21035 |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year February S. Community of Death John J. Kerni Sr 12:10AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Care - Rossville Rosedal-e Baltimore If Under 24 Hrs. If Under 1 Ye 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours MAM 20F 8 212-16-8149 march 15,1921 Germani Usual Rasidance of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 S.A Avenue Fuller 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yes 2 □ No of Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 200 No Specify Whit 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grads completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Phumbir Self-employed 10 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) seong Kern WINKler 2 reszenz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Betty M. Kern-Fuller Ave Baltmore IMD 21234 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from Stata Feb. 8. 4 Donation 5 Othar (Specify) laney Valley Mem. Gard! Baltimore, MD 2000 22. Nama and Address of Facility Evans Chapel of memores 21. Signature of Funaral Sarvice Licensea ather 8800 Harfurd Rd. Buttmore, mD21234 Enter the disaesa, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, or haart feilura. List only ona causa on each lina. Approximate Interval Between Onset and Death Immediata Cause (Finel disaasa or condition rasulting in death) doustroms Marily Due to (or es a consequence of) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco,use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes ANO 2. 2 No 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Homa 5 ☐ Residence 8 ☐ Other (Specify) 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending invastigation 1 Natural

Physician/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. the USB 88 signed by the at d be detached for Be Completed by page 2 certificate or Attending Physician: director, Certification: To this funeral

After

death.

To the Hospital or Attend within 24 hours after deat To the Funeral Director:

Physician

Examiner

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

10a Stata

Funeral

Director

notifie

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Berrie

Pagas 1 and 2 should be tiled within 72 hours after that of Health's Adjoint.
And If I then 27 is marked other than "natural", or lies and or other transmitted owner, the Medical Examines usy or other transmits event, the Medical Examines

Baltimore, Maryland 21215-0020

25. Was casa refarred to medical examiner?

6 Could not be datamined

1 Yes 2 No 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)

2 Accident

4 Homlcide

3 Suicida

Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, data and place, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner status.

29b. Signatura and little of certified

29c. License number 2

#105

29d Data signed (Month, Day, Year)

State

Registrar

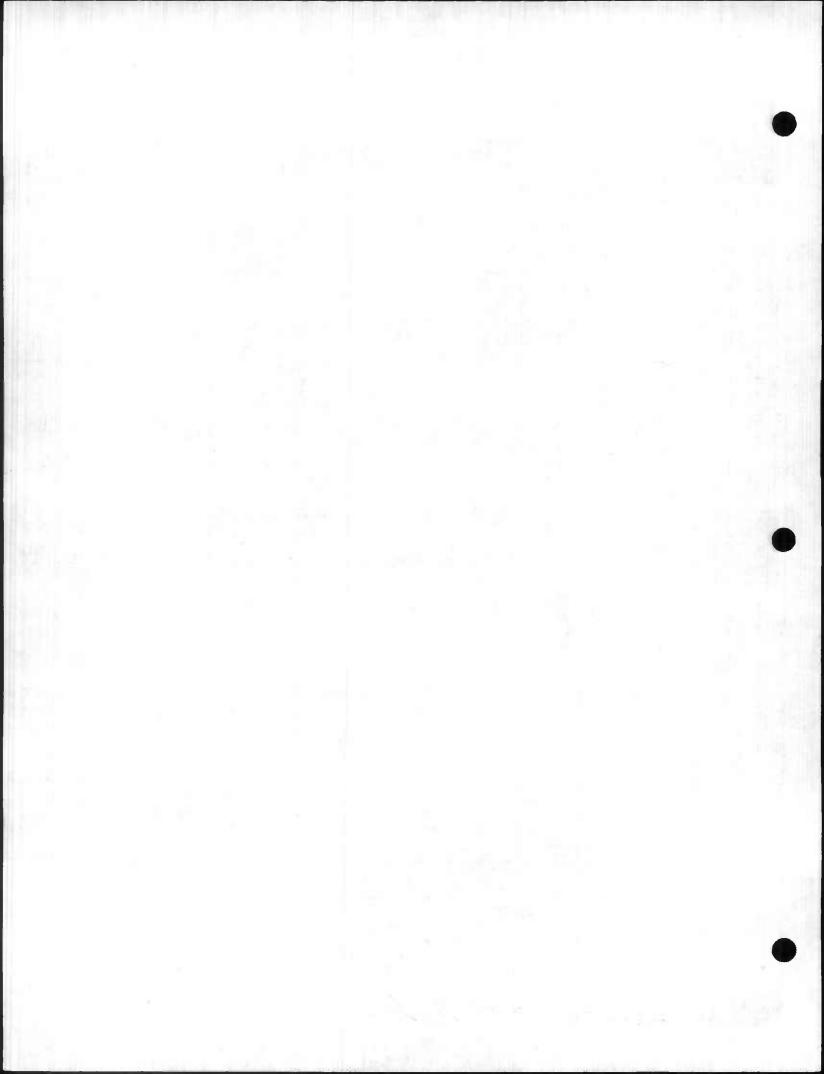
Medicai

a 31. Data filed (Month, Day, Year) 11 2000

ton 32. Registrar's Signafura

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

racker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth **Physician** Kruemme 1340 February ElizAbEtH /Medical 7,000 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Augsburg Lutheran Home Woodlawn Baltimore 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs.
Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthpieca (Stata or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 215-01-1595 Director 91 Yrs Dec. 28, 1908 Maryland Usuel Residance of Decaden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore 1 Yas 2 No Director Woodlawn 10e. Street and Number 10f. Zip Coda 10a. Citizen of Whet Country? ŏ items 23a 6811 Campfield Road 21207 Funeral U.S.A. death 12. Was Decedant Evar in U,S. Armed Forcas?

1 Yas 2 No 13. Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack White atc 1 ☐ Nevar Married 2 ☐ Merried Baitimore, Maryland 21215-0020 ŏ If Yas, Giva Yaar or Dates: 1 ☐ Yas 2 ☑ No Specify: by Specify: White 3 Widowad 4 □ Divorced "natural", Completed 15. Dacedant's Education (Spacify only highast grada completed) 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Menlel Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Medic. Elemantary/Secondary (0-12) Collaga (1-4or 5+) Insurance Secretary 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) unk unk 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Steta, Zip Code) Alma Brown (Niece) 1504 Clairidge Road, Baltimore, Maryland 21207 20b. Piaca of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 2/12/00 Elkridge, Maryland 21. Signatura of Fundal Service Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Entar tha disaasa, or complications that ceused the deeth. Do not antar the mode of dylng, such as cerdiac or raspiratory arrest, shock, or have failura. List only one cause on each line. ervei Batwaan Onset end Daath **Physician** /Medical Immediata Cause (Final disease or condition rasulting in death) Atherosclevatic Cerebral Vascular 400V3 **Examiner** Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasuiting in daeth) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consaquance of): for use as Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably Tunknown 1 ☐ Yes 2 ☐ No Records, by 24b. Ware autopsy findings aveilable prior to complation of cause of daath? Completed 24e. Was an autopsy performed? page 2 s 1 ☐ Yas 2 No 1 Yas 2 No Division of Vitai or Attending Physician: Be 25. Was case rafarred to madicei 28. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Frigary within 24 hours after death. To the Funerel Director: After this c Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 PNo 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 5 Panding invastigation 1 Neturei 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, streat, factory, office building, atc. (Specify) 4 Homicide 29e. Cartifiar 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, dete end place, and dua to tha ceusa(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the ceusa(s) and mennar stated. Medical (Check only one) 29b. Signetura end titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 737573 30. Nama and address of person who completed causa of deeth (Itam 23a) (Type, Print) 7220 Park Heyhots Battime MD 21708 Top Zibell KAD Ave

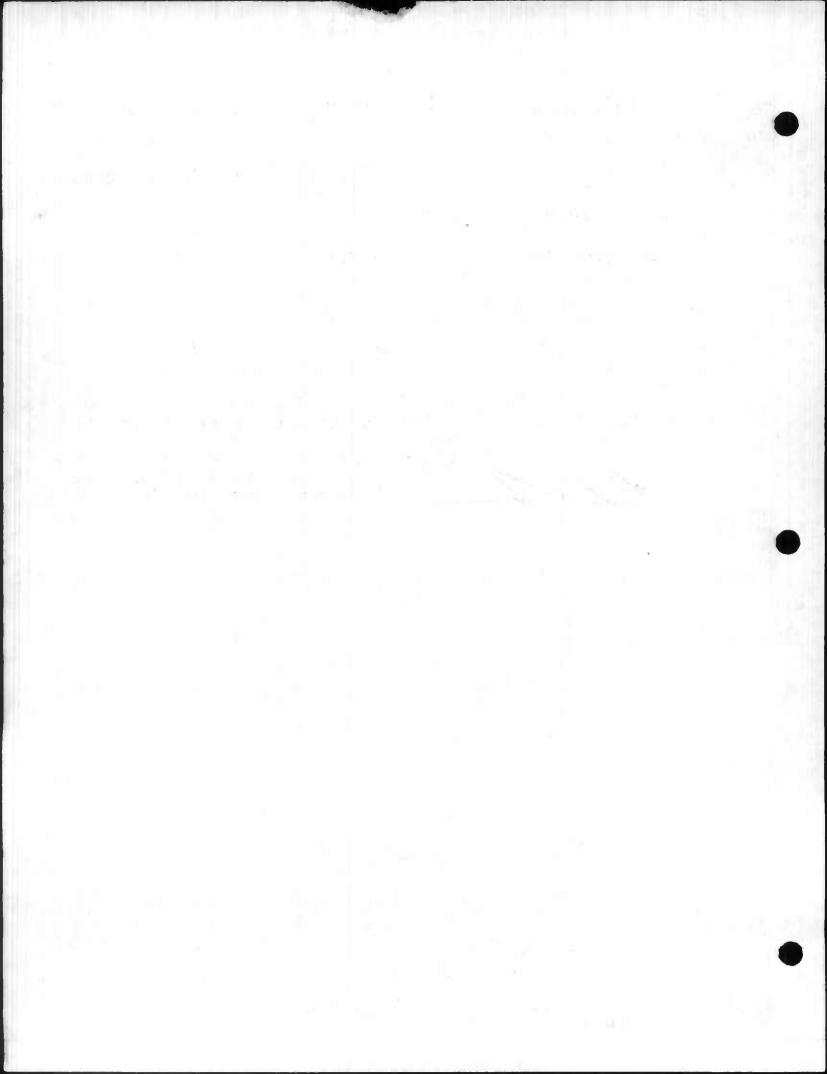
Registrar DHMH 16 Rev 6/95

State

31. Data fitad (Month, Day, Year)

FEB

32. Ragistrer's Signature



Please Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month B Charlotte E. Kight 9:45 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTMORE TURAC tanes If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 21XF Yrs. 214-14-9066 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Rumford Drive #202 21228 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Merifai Sfefus Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Howard County Elementery/Secondary (0-12) College (1-4or 5+) Board of Education Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Edgar T. Sawver Georgia Brown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Richard Kight (Son) 1112 Vineyard Hill Road, Catonsville, MD 21228 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2/12/00 Marriottsville, MD 4 Donetion 5 Dother (Specify) Entombment Crestlawn Mausoleum 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Service License 小九 Ke 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respirefory errest, shock, or heart fellure. List only one cause on each line. Approximete tntervel Between Onset and Death Immediate Cause (Final NEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e consequence of): Due to (or es a consequence of): Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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28a-1

must be

"natural", or hama 23a or

Hiled within 2 Hygiene.

Department of Health and Mental F Important: If New 27 is marked off any Injury or other traumants

Pages 1 and 2 should nant of Health and Men

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

by

Be Completed

Certification: To

Medicai

certificate

of

Hospital or To the Hospital

To the Function

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Daath 28a. Dete of Injury 28b. Time of 1 Neturel

5 Pending investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29e. Cartifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated.

1 ☐ Yes 2 ☐ No

29c. License number

29d. Date signed (Month, Day, Year) 2000

30. Name and address of person wno completed cause of death (ttem 23a) (Type, Print)

N. Rolling Rd. BALTIMORE, HD 21228 1120 BARBARA 31. Dete filed (Month, Day, Year)

State Registrar

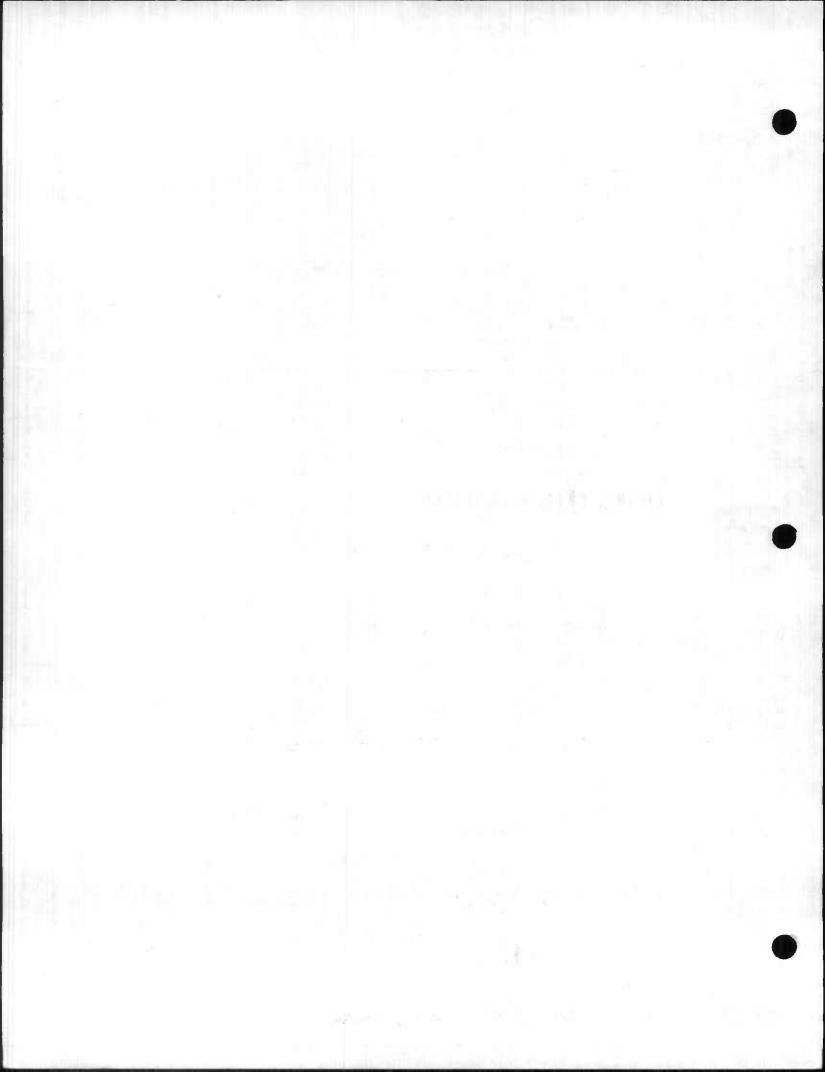
FEB 11 2000

32. Registrar's Signeture

| | F.H. G780 | | O JAB | | | ertificate | | | | 2. Date of De | giene () | 04 | 243 |
|------------------|--|---|--|--|--------------------------------|--|------------------------|------------------------------|---|---|-----------------------------------|-----------------------------------|---|
| ian | Dorothy | | Klingelhofe | one. | | | | | | Month Februa | | , 2º0°00 | 1:10pm |
| cal _ | | | n, give street end nu | | | | 4 | lb. City, Tox | | cation of Deet | | y of Death | |
| | Greater | Balt | imore Me | dical | Cent | er | | Tow | son | | Ba | altimo | ore |
| | 2905 ial Security 248 - 30 - 535 248 - 03 - 535 | U | 6. Sex 1 □ M 2 □ F X | 7. Age (In yr. 74 | s. last birthdaj Yrs. | Months | 1 Year Days | If Under a | 24 Hrs. Min. | 8. Dete of Bi (Month, De December | | 9. Birthple Country Columbi | ce (Stete or Foreign y) A, S.C. |
| - | Jsual Residence o Oa. State | 10b. County | | 10c. C | City, Town or I | ocation | - | | | | | 100 | d. Inside City Limits |
| ō | Maryland | Baltimo | a City | Ral : | timore | | | | | | | | 1 ☐ Yes 2 ☐ No |
| - Y | Os. Street and Nu | | ic dicy | IMI | CHIELC. | 10f. Zip | Code | | | | 10g. Citizen of | What Country | y? |
| | 3939 Rolan | d Avenue | | | | 2121 | 1 | | | | USA | | |
| Funeral | 1. Marital Status | | 12. Wes Dec | edent Ever in | U,S. 13 | Was Deced | ent of H | ispanic Orig | pin? (Sp | ecify Yes or No Rican, etc.) | - 14. Ra | ce - Americar | |
| | 1 Never Men | | | 2 X No | | 1□ Yes 2 | | Specify: | | , , , , , , , | Specia | he . | |
| 2 | 3 🖟 Widowed | | Yeer or D | etes: | 1 10 0 | | | * | | | | Wille | |
| Completed | | | st grade completed) | | (Giv | edent's Usue e kind of wor DO NOT us | k done d se retired | ation during most f) | of work | ing | 16b. Kind of B | Susiness/Indu | istry |
| E | Elementary/Sec 12 | ondary (0-12) | College (| 1-4or 5+) | Head T | | | , | | | Provider | nt Savin | nos Bank |
| 9 | 7. Fether's Name | (First, Middle, | | | TRACE I | | | 18. Mother | r's Name | (First, Middle | , Maiden Sumai | | go tarik |
| | Claud Fran | klin Mar | tin | | | | | Cara L | æ St | eward | | | |
| | 19a. Informant's N | leme/Reletions | hip (Type, Print) | | 19b. Mai | ling Address | (Street | and Numbe | r or Aur | Al Route Numb | er, City or Town | , State, Zip C | Code) |
| | Beverly A | Ousimano | (Daughter) | | 819 W | est Jan | retts | ville | Road | Forest | Hill, Man | yland 2 | 1050 |
| 2 | On Method of Dis | | 3 DRemovel from | | Place of Disp cemetery, cri | osition (Nem emetory or ot | ne of ther plea | ×e) | 1 | Date | 20c. Location | - City or Tow | m, Stete |
| | | 5 Other (S | | | rdens of | Faith 1 | Febru | ary 9, | 2000 |) | Baltimore | e, Maryl | and |
| | 23a. Pert1. Enter shock, or her shock, or her disease or conditions of the second states of t | (Final | complications that conly one cause on e | caused the december line. | ath. Do not e | nter the mode | air F e of dyin | Road Ba | 1time | ore, Mary or respiratory a | land 2123 rrest, | 1 | Approximeta ntervel Between Onset end Death |
| 2 2 | Sequentially list or farry, leading to in ause. Enter Und Cause (Disease or hat initiated event esulting in death) | 5 | b | Sep ⁴ | ns | | u | ry | ea | leur | v | | |
| oy rayalcianymen | Pert II. Other signi | ficant condition | ns contributing to de | eath but not re | sulting in the | underlying ca | ause giv | en in Pert I. | | | / | | the cause of death? |
| | | - CE | noua | z ac | tey | di | M | an | <u>, </u> | | en eutopsy ormed? | oom | e autopsy findings lable prior to pletion of cause seth? |
| Completed | | | | | | | | | | 10 | Yes 2 No | 10 | Yes 2□ No |
| 0 | 5. Was cese referance? | / | Hospital: | | | | Oth | oc. | | (Check only | | | |
| 2 2 | 1 ☐ Yes 2 ☐ 7. Manger of Dea | | 101 | | 28b. Time | | ^ | 4LJ NUI | | | dence 6 Oti | | |
| Certification: | 1 Netural 2 Accident 3 Suicide 4 Homicide | 5 Pendin investig 6 Could r determ | etion ot be ined 28e. Place | of Injury th, Day Year) of Injury - At ng, etc. (Spec | tnjury | М | | k?` Yes 2□h | No | | Street and Num | | Route Number, |
| | 29a, Certifier (Check only one) | 1 Certifyin 2 Medical I | g Physician: To the Examiner: On the ba and meni | best of my kn asis of examin ner steted. | owledge, dee etion and/or i | th occurred envestigation, | et the tin | ne, date and pinion, deet | d place, i | end due to the ed at the time, | cause(s) end m dete and plece, | enner es ste , end dua to t | ted. the cause(s) |
| X 2 | 9b. Signature and | rud | oun | 5 | | | | number 273 | 2 | | 29d. Date signe | ed (Month, De | OOO |
| 3 | 0. Name and edd | ress of person | 4 BESC | e of death (Ite | m 23a) (Type | , Print) | 11 | CHAS | 0,5 | c (1 | Balto | 11. | 21701 |

DHMH 16 Rev 6/95

Klingelhofer,

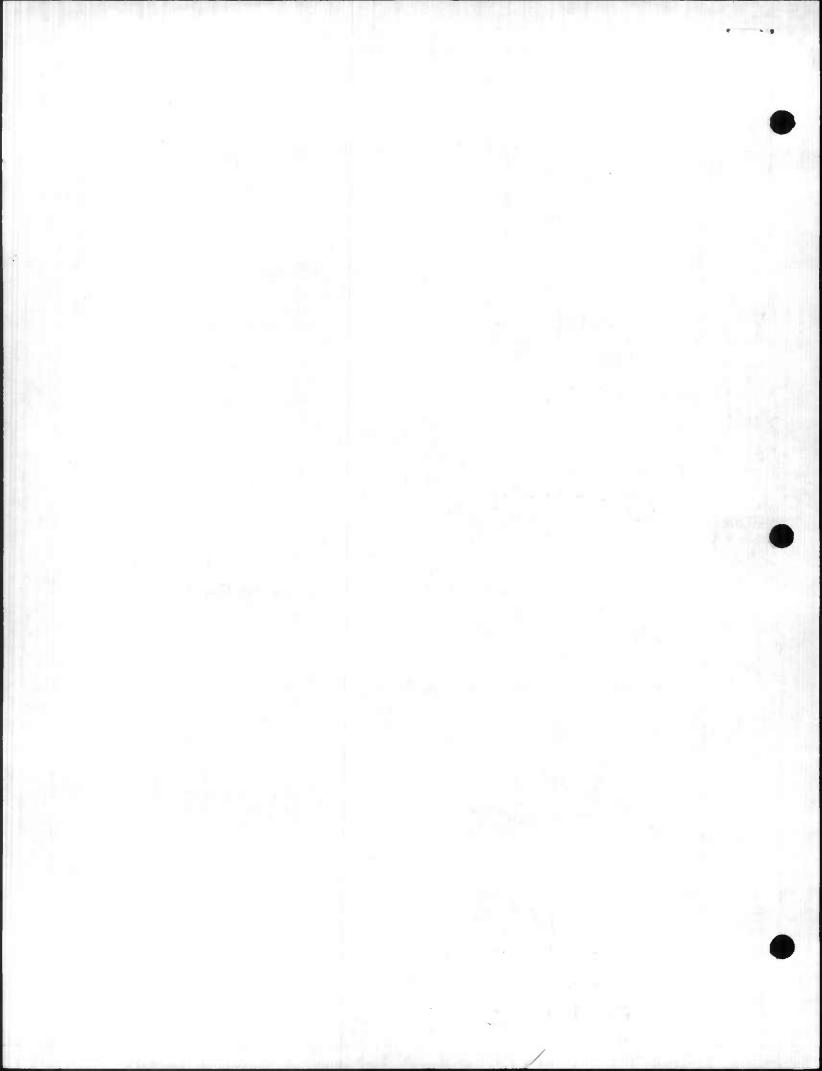


Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 4300 Month **Physician** ambert 00 2 lliam /Medical Both More Birth (Month, Day, Ye Cept. 18, 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mary and Mos 7. Age (In yrs. last birthday) Yrs. of Universi HoSOITU xtimore 6. Sex 1 M 2 F 5. Social Security Number 9. Birtholace (State of Foreign **Funeral** Year) 1928 Mary Land Months Days Director 216-24-0089 Usuet Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or hama 23a or 28a-f shov traumatic event, the Madical Exercities must be notified as 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21207 United States 6501 Gilmore Street Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11 Merital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygione.
Intel filem 27 is marked other than "natural; or the lary or other traumatic event, the Medical Entities into or other traumatic event, the Medical Entities. 1 X Yes 2 No
If Yes, Give
Yeer or Detes: Korea 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 12th Grade Salesman B.P. Oil 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Sebastian Lambert Elizabeth Cecelia Leibaugh 19e. Informant's Neme/Retetionship (Type Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ruth Lambert - Wife 6501 Gilmore Street; Woodlawn, Maryland 21207 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Buriet 2 ☐ Cremetion 3 ☐ Ramoval from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 2/12/2000 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 ₹. M00869 pl d 23a. Pat 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shows on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final disaasa or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): pul Box 68760. Physician/Medical the Due to (or es e consequence of) 80 for use signed by the signed by the signed for the signed s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3/2 Probably 4 Unknown 1 Yes 2 No Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peeu completion of cause of death? page 2 has 20 No 2 No 1 Yes 1 TYes certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of After 1. Netural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifier Le Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner, On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the pietely On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) \$ 29b. Signeture and tiple of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 0 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Varyland 32. Registrar's Signeture Univer 31. Data filed (Month, Day, Year) Schen. State Douker FEB 1 1 2000 Registrar

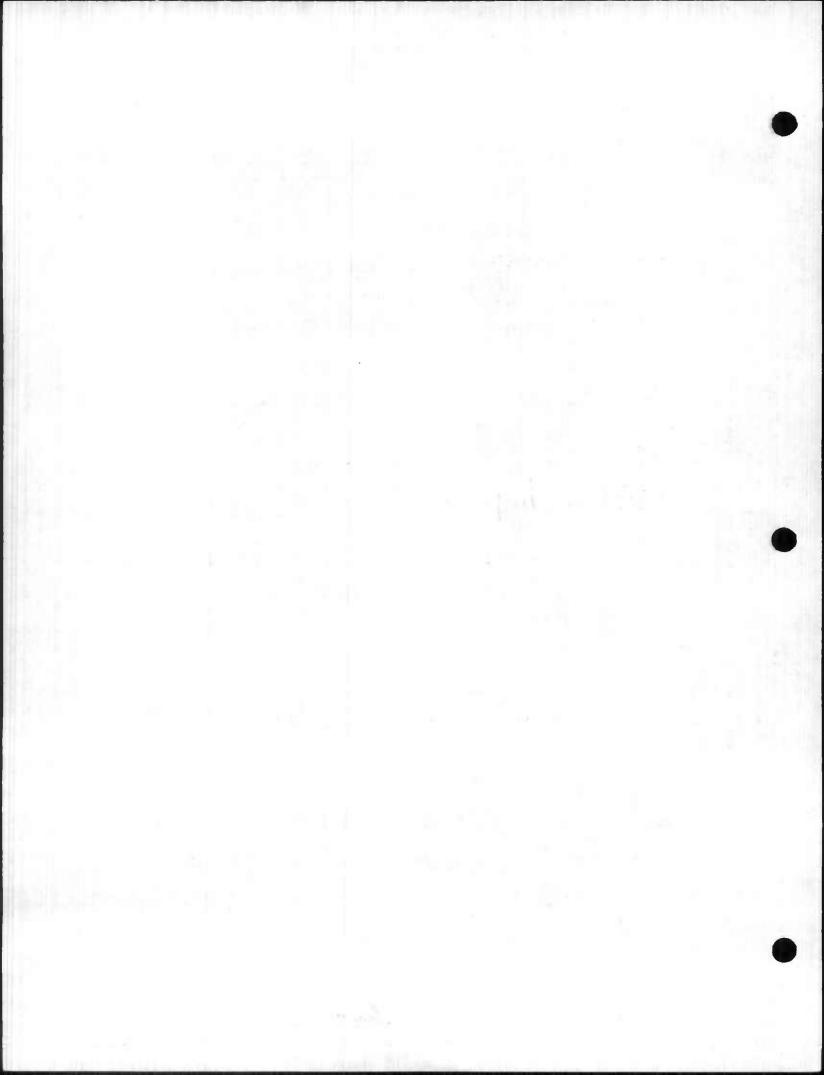
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| | | Certificate of Death | Red | z. No. | 04245 |
|-------------------|--|---|------------------------------------|--------------------------------|--|
| O. | | 1. Decedent's Name (First, Middle, Last) | 2. Date of Death | | 3. Time of Death |
| | Physician /Medical | Theodore Lorenzo Jenkins | Month 02 | Day Year 05 2000 | 4:10pm |
| | Examiner | 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Lo | | 4c. County of Dea | O D HI |
| | | Manor Care Nursing Home Baltimon | ce | | |
| П | Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Months Days Hours Min. | 8. Date of Birth (Month, Day, 1 | Year) 9. Bir | thplace (State or Foreign ountry) |
| L | Director | Usual Residence of Decedent | 11 07 | 46 | M.D. |
| | Duel 8 | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | Many Trash | MD NA Baltimore | | | 1 No Yes 2 No |
| | or 28a-f a | 10e. Street and Number 10f. Zip Code | 100 | g. Citizen of What C | ountry? |
| | ter deeth with the Maryler flems 23s or 28s-f show the mars be notified at Tuneral Director | | | U.S.A | |
| | r kems 234 | 11. Manital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo | ecify Yes or No- Rican, etc.) | 14. Rece - Ame Black, Whi | |
| 20 | off, or h | | | Specify: | 197,542 |
| 21215-0020 | | Year or Dates: | 1 44 | Bl | ack |
| 15 | n 72 | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired) | ing | 6b. Kind of Business | /Industry |
| 212 | filed within Hygiene. There then "ent, it is the | Elementery/Secondary (0-12) College (1-4or 5+) 11th grade na Home Improvement | | Privat | 0 |
| | EIDE . | | e (First, Middle, Ma | | |
| Maryland | | William Jenkins Marie S | Smith | | |
| lan | d 2 should the and Men 7 is marke treumetic | 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Run | al Route Number, | City or Town, Stete, | Zip Code) |
| | | Juanita Sanders-Sisters 4701 Marling Road, | | | 21208 |
| Baitimore, | S O T | 20a. Method of Disposition 11 Buril 2 Cremation 3 Removal Irom State 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date 20 | Oc. Location - City or | Town, State |
| tim | | 4 Donation 5 Other (Specify) King Memorial Park 2 | /11/2000 | randal | lstown, Md |
| Bai | Departm Departm Importar any Injur | 21/Signature of Funeral Service Licence 22. Name end Address of Facility March F/H West | | | |
| _ | 703 e a | 1300 Wabash Ave | Baltmo | ore, Md | 21215 |
| | | 23a. Pept Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac of shock of heart failure. List only one cause on each line. | or respiratory arres | et, | Approximete interval Between |
| | Physician /Medical | Immediate Cause (Fire) | | | Onset and Deeth |
| | Examiner | Immediate Cause (Final disease or condition resulting in death) | 2 | | 1 |
| | | Due to (or as a consequence of): | Cale | Rolls | 1 |
| | n and ietransit | Sequentially list conditions b. GWD TAGE MULTIPLE Due to (or as a consequence of): | 3778 | 160113 | 1 |
| Ó | | Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events Due to (or as a consequence of): C | | | 1 |
| 68760, | licate be a physician is the burie | Cause (Disease or trijury thet initiated events resulting in death) Last Due to (or es e consequence of): | | | |
| | E 08 0 | | | | |
| Вох | v requires that the death cert been signed by the attendin should be detached for use leted by Physician/N | d | | | i |
| 0. | the all | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. | 23b. Did tob | acco use contribut | to the cause of death? |
| P.0. | ed by the detache | STATUS PERCUTANTOUS GARTRUSSTOMY | 1 □ Yes | 2 No 3 P | Probably 4 Unknown |
| S, | signe bed by | | | 1046 | 1 |
| OC | The law requires cate has been sign, page 2 should be Completed by | | 24a. Was an performe | | Were autopsy findings evailable prior to completion of cause |
| 360 | 2 20 0 | | | | of death? |
| <u>a</u> | cate h | | 1 ☐ Yes | 2 DONO | 1 Yes 2 No |
| of Vital Records, | Physician: The lew this certificate has b ral director, page 2 siral director, page 3 siral director, page 4 siral director, page 4 siral director, page 4 siral director, page 4 siral director, page 5 siral director, page 6 siral director, page 6 siral director, dire | examiner? | h (Check only one, | | |
| | Physic or this or ral dire | 1 Inpatient 2 EH/Outpatient 3 DOA 4 Vivrsing Ho | me 5 Residen 28d. Describe how | ce 6 Other (Specialist Control | ecify) |
| Division | Attending or death. ector: After by the fune ification | 27. Menner of Deeth 1 Paturel 5 Pending 2 Accident Investigation 28a. Dete of tnjury (Month, Day Year) 28b. Time of tnjury Work? 1 Yes 2 No | | | |
| /ISI | Atten r dea octor sy the | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, lactory, office | | et and Number or F | Jural Route Number, |
| á | tal or Attending P is after death. In Director: After the in by the funers Certification: | 4 Homicide building, etc. (Specify) | City or Town, | State) | March 3 |
| | To the Hospital or Attending Physician: The is within 24 burs after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com | 29a. Certifier 1—Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my online, death occurred.) | and due to the cau | ise(s) and manner a | s stated. |
| | in 24 hours the Funer spletely fill | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | ed at the time, dat | e and place, and du | e to the ceuse(s) |
| | To the comple | 29b. Signature and title of certifier 29c. License number | 290 | d. Date signed (Mon | th, Day, Year) |
| | N | 10024100 | 02 | 1-01-0 | 2000 |
| | 1 1/1 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 0 (00 060 | 20 00 | 2,M02122 |
| | 112 | | (SIND) | 17/19/1 | 611107125 |
| | State | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | |
| | Registrar | FEB 11 2000 Same & Specific | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey 9, 2000 10:42 AM Robert Stavton Lowe, Jr. Ebruara 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) amaritan TIMORE Didas If Under 1 if Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) 1 XM 2 ☐ F Deys 53 Yrs 213-46-2201 1946 Maryland Usuel Residence of Decedent 10a Slata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Nebraska Sarpy Bellevue 10e. Street and Number 10f. Zip Code 10g, Citizen of Whel Country? 2007 Betz Road 33D 68005 United States 11. Meritel Status 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Food Transport Loading Dock Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Mildred Boyd Robert Stayton Lowe, Sr. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly J. Lowe / Wife 2007 Betz Road 33D Bellevue, Nebraska 68005 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 XBurial 2 Cremetion 3 Removel from State Parkwood Cemetery 2/14/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lisensee

Lary R. Williamsee 22. Name end Address of Fecility Leonard J. Ruck, Inc. Funeral Home Gary R. DiGiovanni 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Immediate Ceuse (Finel Hemorrhaa diseese or condition resulting in death) lena Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 25 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dele of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street end Number or Ruret Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dele end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated. 29a. Certifier

be executed Box 68760, P.O. Records, Division of Vital

physician end s the burief-transit 80 for use es signed by the e peed page 2 certificate al or Attending Physician: T s after death. Il Director: After this certificat od in by the funeral director, p To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

must be notified at

items 23s

6

"natural",

Pages 1 end 2 should be filed within: nent of Health end Mental Hygiene. nt: if Itam 27 is merked other than 1

permit. Pages 1 end 2:
Department of Health et
Important: If Item 27 is
any Injury or other trau

Physician /Medical

Examiner

Exami

Physician/Medical

by

Completed

Be

Certification: To

Medical

31. Dete filed (Month. Dev. Yeer)

Baltimore, Maryland 21215-0020

Director

Funeral

p

Completed

State Registrar 29b. Signeture end title of certifier

29c. License number

29d. Dale signed (Month, Dey, Year)

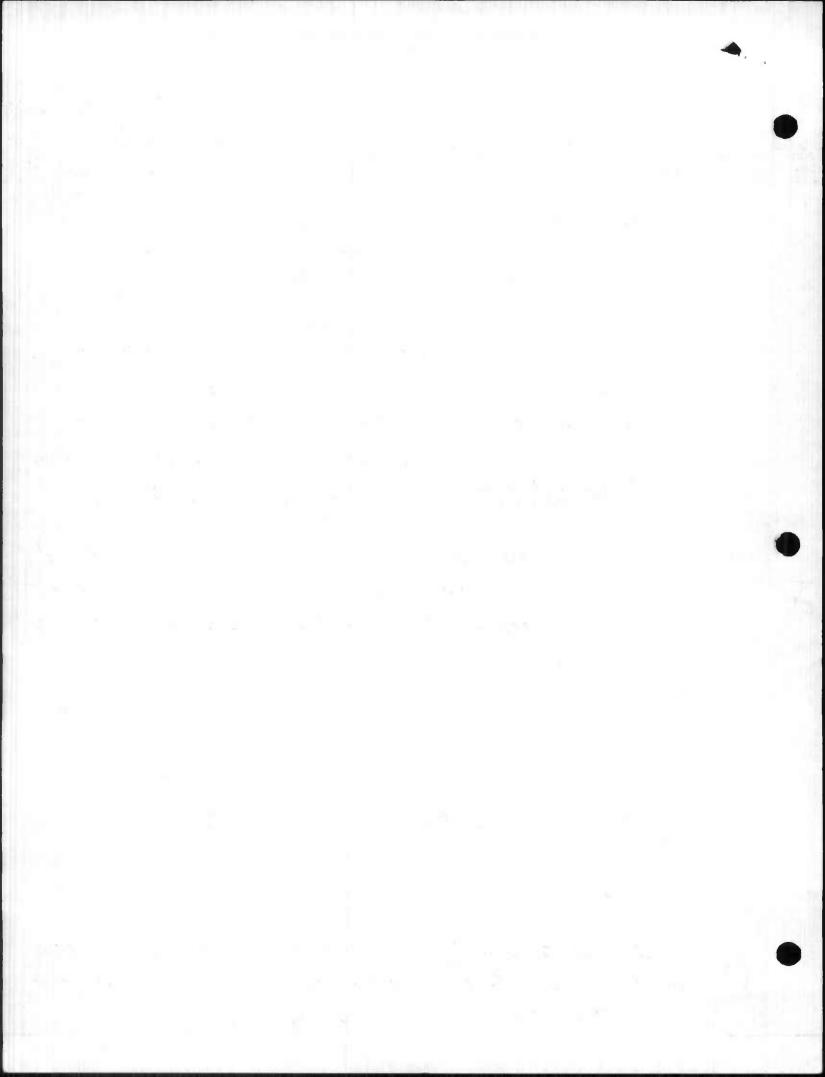
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Good Samovitar

5601 Loch Roven, Baldimo Hospital

32. Registrer's Signeture

DHMH 16 Ray 6/95



Please Type or Print in Black Indeiibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 12:25 pm LAZZA RO 2000 JOSEPH February /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number BA HI MORE

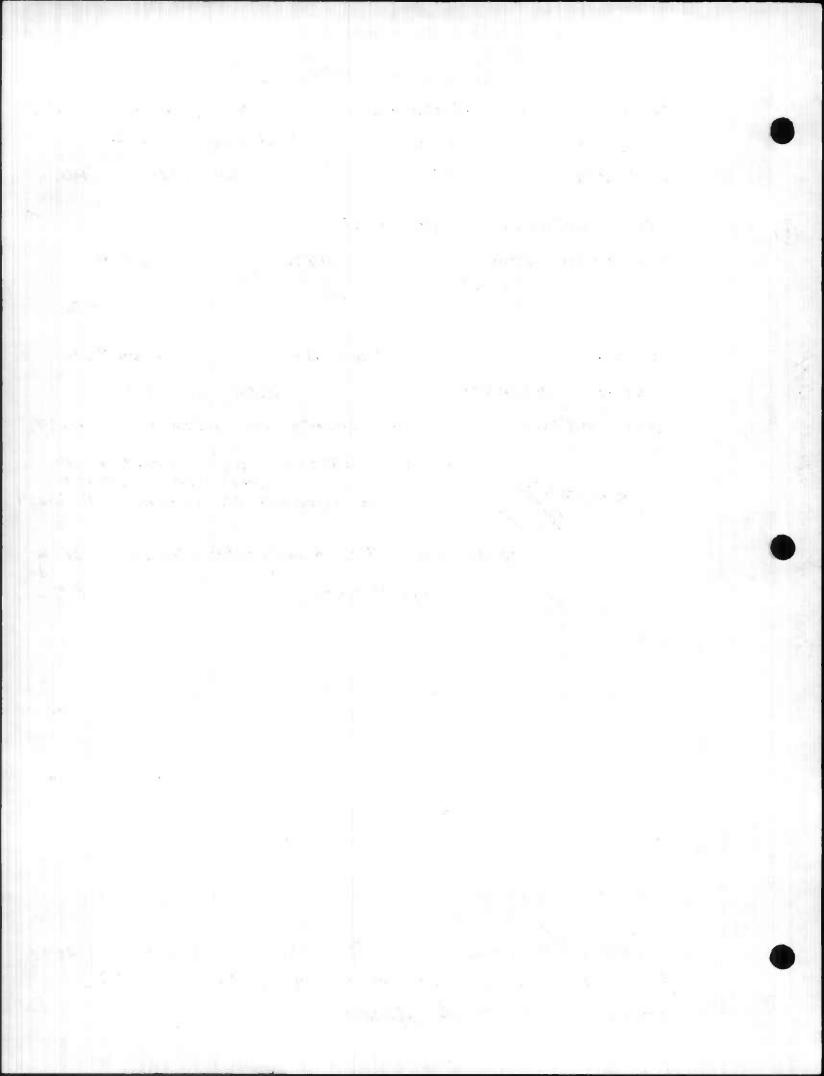
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) N/A HOSPITAL If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) **Funeral** 10M 20 F Months Days Yrs. Director 219-05-5594 JAN 29, 1919 Usual Rasidance of Decedant t0d. Insida City Limits 10a Stata 10b. County 10c. City. Town or Location 1 Yas 2 HO Directo MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ir than "naturel", or items 23a or U.S.A.

14. Race - Amarican Indian, EMGE 21234 Funeral 8710 ROAD 12. Was Dacedanf Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) FURNITURE UNKNOWN FURNITURE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be LAZZARO CULOTTA FRANK ROSE 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Health em 27 EATTMORE MD. 21237
Data 20c. Location - City or Town, Stata JOHN MUR PHY 8307 SAGAMORE ED. 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Data 20a. Mathod of Disposition FEB 9 1 Burial 2 □ Cramation 3 □ Ramoval from Stata MOST HOLY REDEEMER CEN! 2000 4 ☐ Donation 5 ☐ Othar (Specify) BAUTIMORE MO 21. Signatura of Funaral Sarvice Licans 22. Nama and Addrass of Facility EVANS FUNEEAL CHAPEL 8800 HARFORD RD. PARKVILLE, MD. 21234 net causad tha death. Do not anter the mode of dylng, such as cardiac or raspiratory arrest, on each line. . Entar tha disaasa, cook, or haart failura. Lisi Approximata Interval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Final Examiner Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in death) Lest Physician/Medical Dua to (or as a consequence of) 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P. þ Sign B 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? 1 Yas 2 KNo 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 ☐ Yas 2 No 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28c. fnjury at Work? 1 Natural 2 Accidant 5 Panding death. 1 TYas 2 TNo Invastigation after death Director: 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) Hospital or To the Hospital o within 24 hours af To the Funeral D completely lilled i 1 🕰 certifying Physician: To tha bast of my knowladga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 29a. Cartifian Medicai (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 121022 9,2000 Murny na and addrass of person who complated causa of death (Itam 23a) (Type, Print) 8/14/SANDPIPCE CIECUE BACOO. MD 2123 KOWALENSKY State 11 2000 Registrar

DHMH 16 Rev 6/95

219-05-550

(AZZARO)



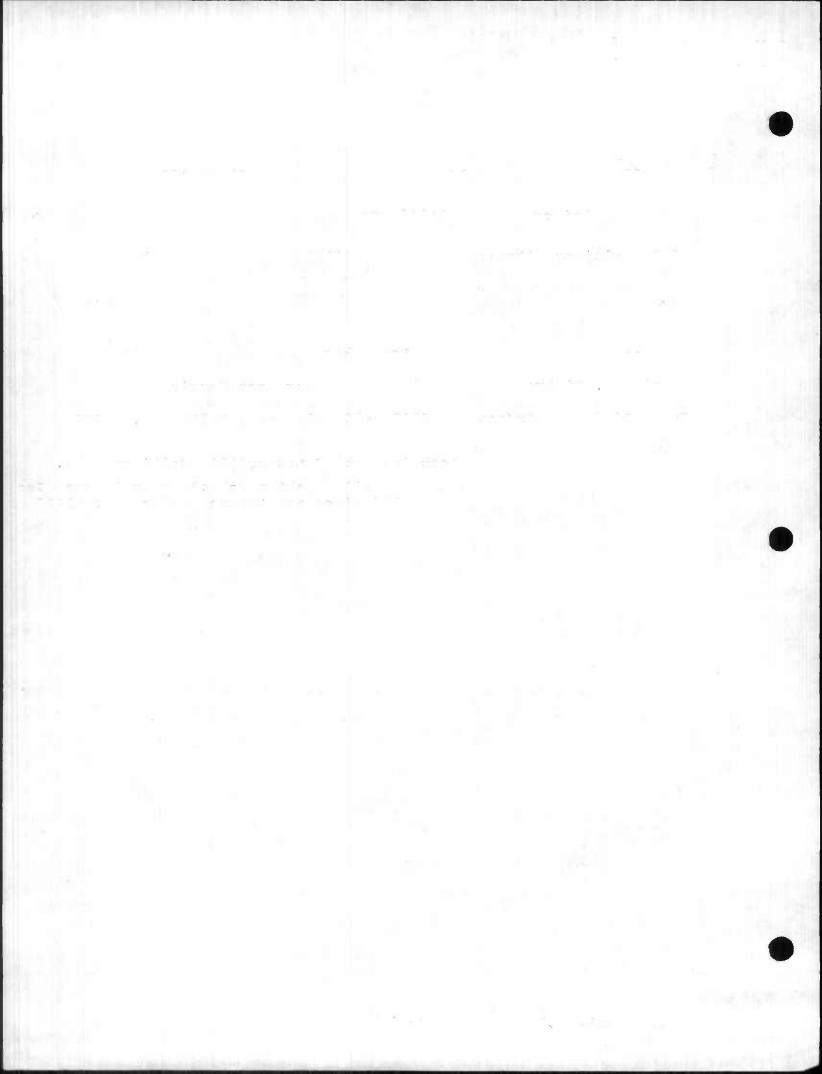
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 5 per fh 2/18/00 G780 yg State of Maryland / Department of Health and Mental Hygiene amend item 4c 29d per fh G780 2/11/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Lindemon 06:29 February 2000 /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death() 4c. County of Deeth Examiner N/A Medical Center

7. Age (In yrs. last birthday) If Under 1 Year University of Maryland Medical Saltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Security Number 26-5720 Birthplace (State of Foreign Country) **Funeral** Months Deys 1□M 2XF Director 70 06 1929 Md Usual Residence of Decedent the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 No Director Md 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 230 6014 Baltimore Street 21207 death Funeral USA | Items Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. a filed within 72 hours after d if Hygiene. other than "natural", or frem Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify à 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental I int: If Nem 27 is marked or Charles H. Liptrap Margaret Ferris 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: if Nem 27 is any Injury or other trau James Lindemon, Jr/son 5911 Robindale Road, Balto, Md. 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method ot Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel trom Stete 4 □ Donetion 5 □ Other (Specify) Lorraine Park Cemetery0211 | Baltimore, Md 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, 21228 23a. Part1. Enter the disclese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel · Acute Promuelocutic disease or condition resulting in deeth) Examiner Due to (or es a gonsequence/of) Examiner physician and the burial-transit that the death certificete be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of) Box 68760. Physician/Medicai Due to (or as a consequence ot) 950 P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Winknown signed l Records, þ 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case reterred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 tnpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. tnjury at Work? 1 Neturel 5 Pending 1 Yes 2 No investigetion 24 hours after death.

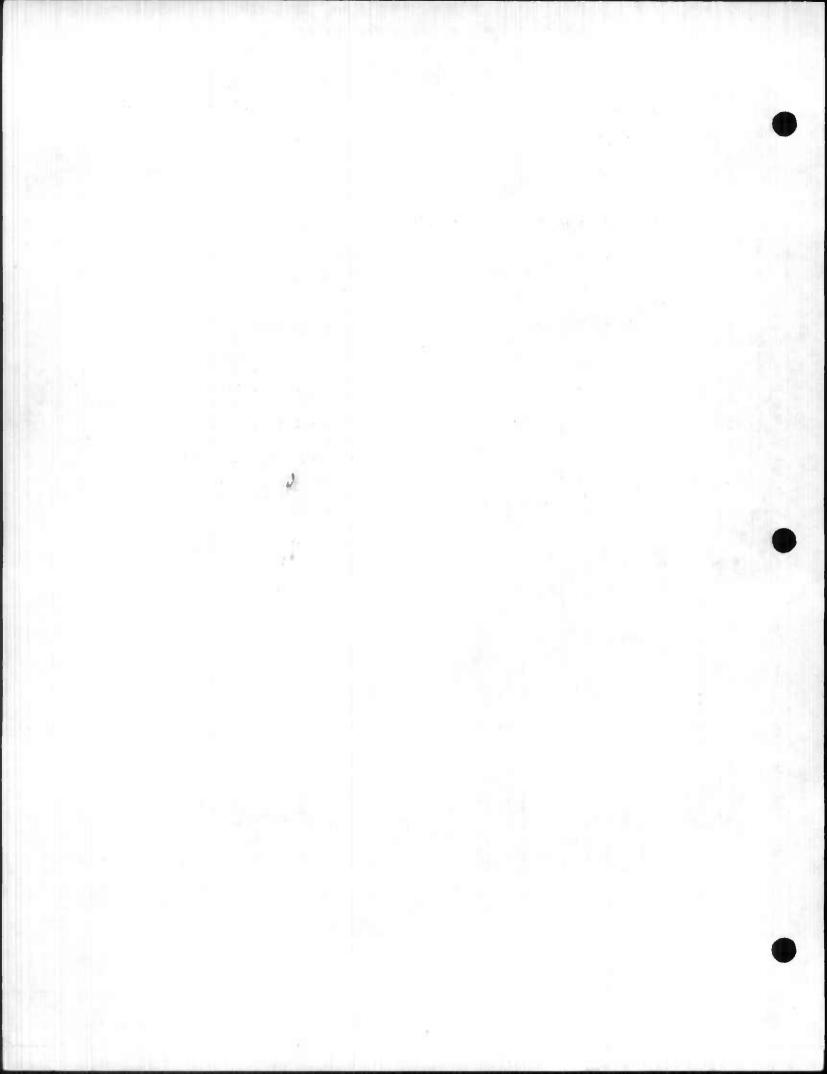
Funerel Director: A 2 ☐ Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. edical 29e. Certifie completaly (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2/10/2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) South Greene Baltimore, MD 21201 Jean R Hou 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

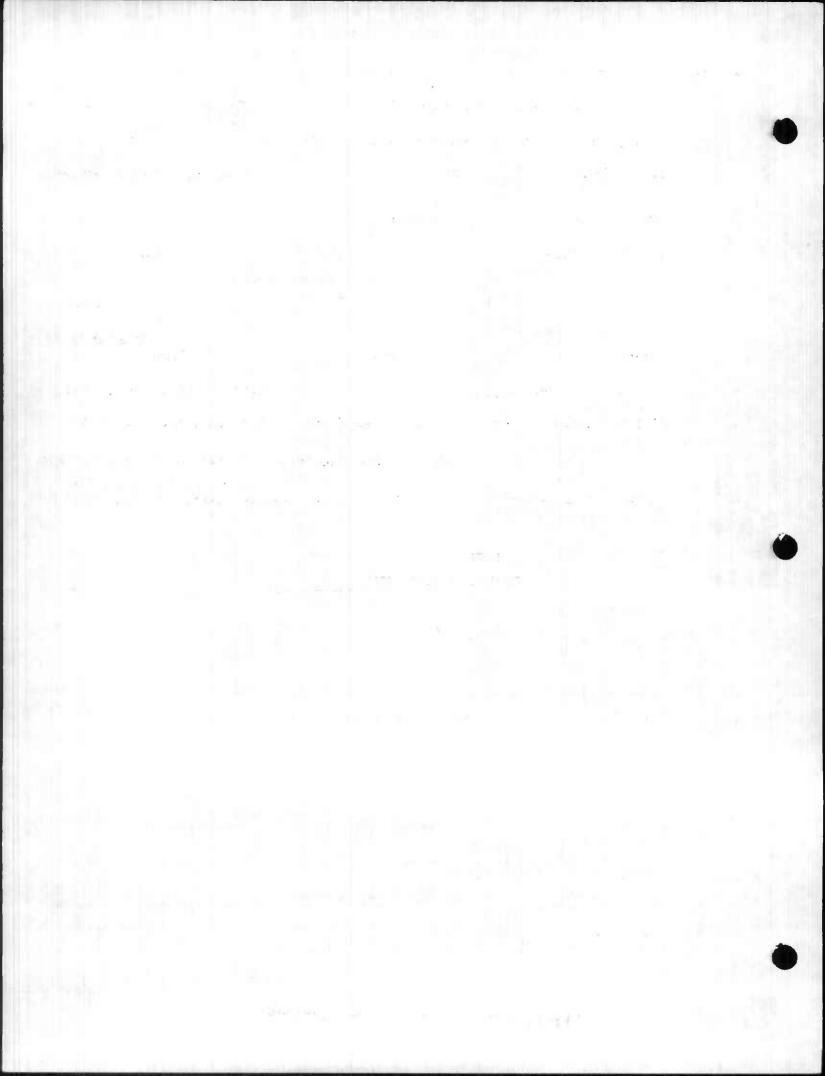
DHMH 16 Ray 6/95



| | Decedent's Name (First, Min | idle, Last) | | Cei | tificate of | Death | 2. Date of Dea | Reg. No. | JU | 3. Time of Dea | | |
|----------------------------|--|---|---------------------------------|------------------|--|---|---|----------------------------|-----------------------------|---|--|--|
| hysician | EVELYN MA | MILLER | | | | | Month FEBRUARY | Day 20 | OOO | 4:30 AM | | |
| /Medical xaminer | 4a Facility Name (If not institu | | ım <i>ber)</i> | | | 4b. City, Town, or L | | | | | | |
| Adminer | CATON MANOR BALTIMOR | | | | | | | | | | | |
| eral | 5. Social Security Number | 6. Sex | 7. Age (In yrs | . last birthday) | If Under 1 Year | If Under 24 Hrs. | | | 9. Birthpl | ace (Stata or For | | |
| or | 214-01-7293 | 1 □ M 2(XF | 92 | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day DECEMBE | R 8,1907 | MAR | YLAND | | |
| | Usuai Residence of Decedent 10a. Stata 10b. Cour | ity | 10c. C | ity, Town or Lo | cation | | | | 10 | d. Inside City Li | | |
| cto | MARYLAND BALT | IMORE | BA | LTIMOR | E | | | | | 1Ã Yes 2□ | | |
| Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of \ | What Count | ry? | | |
| | 502 CHEDDING | 502 CHEDDINGTON ROAD 21090 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Off Yes, specify Cuban, Mexics | | | | | | JNITED S | | | | |
| by Funeral | 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce | arried 1 Yes | orces? 2∰No ive | | Vas Decedent of h FYes, specify Cub □ Yes 2 1 No | dispanic Origin? (Si an, Mexican, Puerto Specify: | pecify Yas or No- o Rican, etc.) | 14. Rac Blac Specify | e · Amarica ck, White, e | tc. | | |
| Donne di lion | | ent's Education hest grade completed) | (1-4or 5+) | (Give | lent's Usuel Occup kind of work done OO NOT use retire | during most of wor | king | 16b. Kind of Bi | | ustry | | |
| | 8 | | 17-01 54) | SEAMS | TRESS | | | Tailo | | | | |
| 9 | 17. Father's Name (First, Midd | | | | | 18. Mother's Neme (First, Middle, Meiden Sumerne) | | | | | | |
| 2 | SAMUEL STEINB | | | 1 | | | E BEATLE | | | | | |
| | 19a. Informant's Name/Relation EVELYN M. GROS | | umen | | | and Number or Ru | | | | | | |
| | 20a. Method of Disposition | SKOPF-DAUGI | | | HEDDINGT sition (Name of | ON ROAD, | LINTHICU | M, MARY 20c. Location - | | | | |
| | 1 Burial 2 □ Crematio | | State | cemetery, cren | netory or other ple | | | | | | | |
| | 4 Donation 5 Other | | LO | | RK CEMET | | 2-9-00 | BALTIMO: | RE, M | ARYLAND | | |
| | 21. Signature of Furieral Servi | , JOHN | 10N | LO | | K FUNERAI NS AVENUE | | MORE, M | ARYLA | ND 21229 | | |
| Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b | | or as a conseq | | | | | 1 | | | |
| | Part II. Other significant condi | d | looth but not so | bion in the | | en in Post I | 23b. Did tobacco use contribute to the cause of death | | | | | |
| | Partit. Other significant cond | nons contributing to d | realth but not res | summy in that ur | loenying cause gr | ven in Parti. | | fes 2 No | 3 Prob | | | |
| | | | | | | | 24a. Wes perfor | en autopsy med? | ava | re autopsy tindin ilable prior to apletion of cause leath? | | |
| To condition | | | | | | | 1 U Y | as 2 No | 10 | Yes 2□ No | | |
| 99 | 25. Wes case referred to medi examiner? | cai | | | | 26. Place of Dee | th (Check only o | ne) | | | | |
| 0 | 1 Yes 2 No | Hospitel: 1 🗆 | Inpatient 2 | ER/Outpatien | t 3□ DOA Oth | ner: 4 Nursing H | ome 5 Resid | ence 6 Oth | er (Specify |) | | |
| cei micanolli. | 3 Suicide 6 Cou | d not be | e of Injury - At h | | M 28c. Injur Wo 1 □ set, factory, office | yat rk? Yes 2 □ No | 28d. Describe h | itreet and Numb | | Route Number, | | |
| | 29e. Certifier 1 Certif | ring Physician: To the | best of my kno | owledge, deeth | occurred at the tir | me, date and place | City or Tow | cause(s) and ma | anner as str | sted. | | |
| edicai | (Check only 2 Medic one) | al Examiner: On the b and man | asis of examination and stated. | ation and/or inv | estigetion, in my o | pinion, death occu | rred at the time, o | lete and plece, | and due to | the cause(s) | | |
| 2 | 29b. Signature and title of certi | Rough | 8 | | 29c. Licens | 40521 Wilke | | Februa | | | | |
| | 30. Name and address of person | | se of death (ite | 1 | Vint) 3350 | wilke mp | NS AVE | nue 8 | rute | 302 | | |
| State istrar | 31. Date filed (Month, Day, Yea | 1 2000 J | Registrar's Sign | ature 4 | Mimor | - | | | | | | |



| tem#23a perPhyG780 2/11/2 | 000 EW | Cert | ificate of | Dealli | 2. Date of De | Reg. No. | 1 | 3. Time of Deeth |
|---|---|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--------------------------------|--|
| EDI | VA MAN | NON | | 4. 0. | JANUAR | y /3, 2 | Year 2000 | 7.45AM |
| 4a Facility Name (If not institution, give s | | CENTE | | | or Location of Deat | h 4c. County | | |
| ST. ELIZABETH 5. Social Security Number 6. Sex | | s. last birthday) | If Under 1 Year | BALTO | | rth | N/A | ce (State or Foreign |
| | M 2⊠F 80 | Yrs. | Months Deys | Hours N | lin. 8. Dete of Bir (Month, De Nov. 1 | 6, 1919 | Massa | ce (State or Foreign chusetts |
| 10a. State 10b. County | 10c. C | City, Town or Loca | ation | | | | 100 | f. Inside City Limits |
| Maryland N/A | В | altimore | 9 | | | | | 1⊠Yes 2□No |
| Maryland N/A 10e. Street and Number | _ | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Country | n |
| 3320 Benson Avenu | e | | 212: | 27 | | U.S | | |
| 11. Marital Status 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced | Wes Decedent Ever in Armed Forces? □ Yes 2 No If Yes, Give Yeer or Detes: | 11, | es Decedent of l Yes, specify Cub | an, Mexican, Pu | (Specify Yes or No Jerto Rican, etc.) | | e - Americar ck, White, etc | |
| 15. Decedent's Educ | atlon | 16a. Decede | nt's Usuel Occu | pation | | 16b. Kind of Bu | siness/Indu | stry |
| (Specify only highest grede Eiementary/Secondary (0-12) 12th | College (1-4or 5+) | - (Give ki life. Do Cler | ind of work done O NOT use retire CK | during most of | working | Anne A | | County |
| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's | Name (First, Middle | , Maiden Sumem | 10) | |
| | hn Lanont | | | | Elise | (not a | | |
| 19a. Informant's Name/Relationship (Ty) | 4 - | | | | Rural Route Numb | | | |
| William Mannion 20e. Method of Disposition | / Son | 2903 . Ptece of Disposi | Rose Cr | own | Pasadena | , Maryla 20c. Location - | | |
| 1 Buriai 2 ☐ Cremation 3 ☐ R | emovat from State | cemetery, creme | etory or other ple | | 1/15/00 | | 1 | |
| 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licanse | | ew Cathe | Name and Addr | | | | | Maryland |
| I Sent Su | | 400 | 01 Ritch | nie High | way Bal | | Md. 2 | 1225 |
| 23a. Pert1. Enter the disease, or compli- shock, or heart faiture. List only on | cations that caused the de- e cause on each line. | ath. Do not enter | the mode of dy | ing, such es car | diec or respiratory a | arrest, | | Approximate nterval Between Onset and Death |
| immediate Cause (Final disease or condition resulting in death) e | ASPIRATION | | PNEU | noNIA | | | | DAYS |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underking | TERMINAL AGO | NAL CONDI | PICE OF): NON SPIRI | 1-110N | | | | DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or es a consequi | | 1000 | | | i , | 4.0 |
| cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last | Due to | Or as a conseque | | DEME | NTIA | | | /EARS |
| Cause (Disease or Injury that Initieted events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions con ATHEROSCLERG | ributing to death but not re | suiting in the unc | leriving cause of | ven in Part I | 23b. Did | tobacco uae cor | ntribute to t | he cause of death? |
| ATHEROSCLERO | | | | DISTER | 10 | Yes 2□No | 3 Proba | |
| | | | | | 24e. Was | s an autopsy ormed? | eveil | e autopsy findings able prior to pletion of cause eath? |
| | | | | | 1□ | Yes 20 No | 10 | Yes 2 No |
| 25. Wes case referred to medical examiner? | | | | | Deeth (Check only | one) | | |
| 1 Yes 2 No | | ☐ ER/Outpatient | 3LI DOA | | g Home 5 ☐ Res | | | |
| 27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation | 28e. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | ryat ork?]Yes 2□No | 28d. Describe | how injury occur | red | |
| 3 Sulcide 6 Could not be 4 Homicide determined | 28e. Placa of Injury - At building, etc. (Spec | | et, factory, office | | 28f. Location City or To | (Street end Numb own, Stete) | er or Rurel I | Route Number, |
| 29a. Certifier 1 Certifying Physical Check only 2 Medical Examin | clan: To the best of my kr er: On the basis of examir and manner stated. | nowledge, death on ation and/or Inve | occurred et the t estigation, in my | ime, date and pl opinion, deeth o | ece, end due to the courred et the time | cause(s) and ma , date and place, | anner as stat and due to t | ted. he cause(s) |
| 290. Signature and title of certifier | | | | se number | | 29d. Dete signe | d (Month, De | ey, Year) |
| My Vasav | 1thalcum | MMD | DU | 12510 | | JANUAR | 4 13 | , tow |
| 30. Name and eddress of person who co M. VASANTUAL 31. Date filed (Month, Dey, Yeer) | mpleted cause of death (Ite | em 23a) (Type, P | rint) | UTAW | ST # 40 | 7. MD | 2/20 | 1 |
| MUNASANTUAL | WINT ! | 111 00 | 1 1- 1- | 0 11 .0 . | , | . / | | 1 |

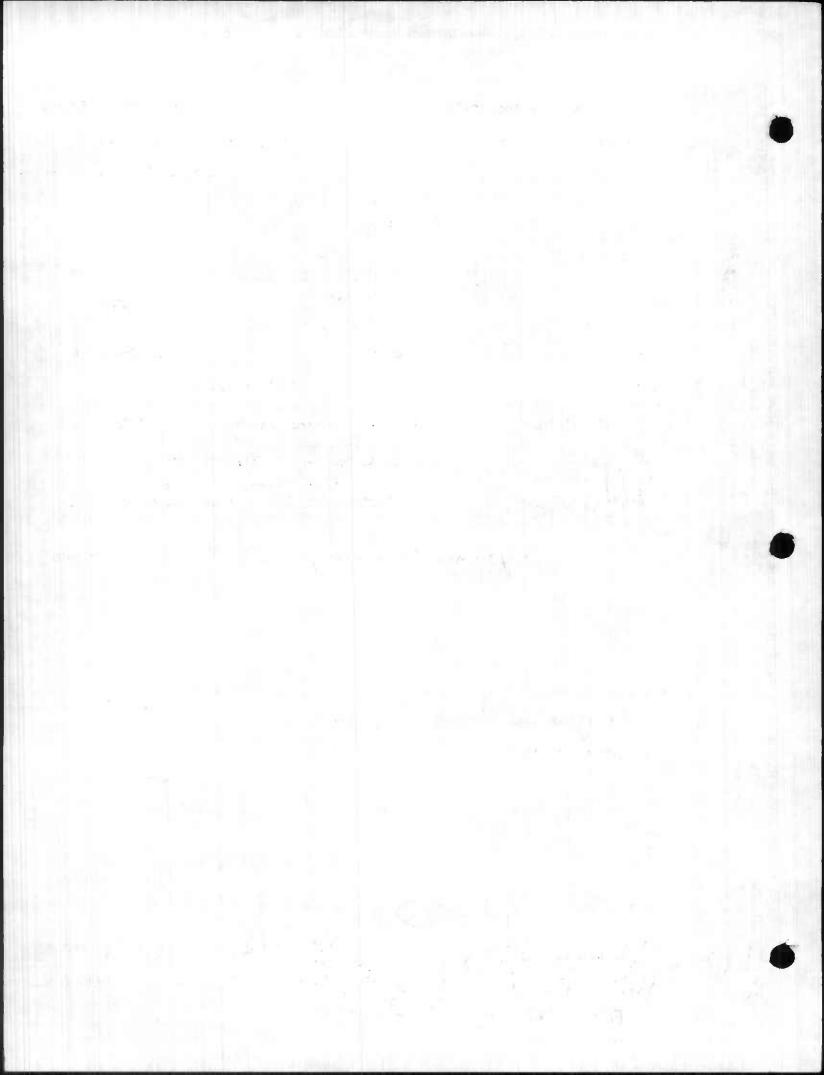


State of Maryland / Department of Health and Mental Hygiene 11 1251

| | 1. Decedent's Neme (First, Middle, L | ast) | | Certifica | | | 2. Date o | | | | 3. Time of Death | |
|---|--|---|--------------------|---------------------------------------|-------------------------|---|---------------------------------|-------------------------|--------------------------|---------------------------|---|--|
| Physician | Helen Ma | ay Marchand | | | | | Feb. | |)2 2(| Year 000 | 10:00 AM | |
| /Medical | 4a Facility Neme (If not institution, gr | | - | | | 4b. City, Town, or | | | c. County | | 10:00 AM | |
| Examiner | Levindale | | | | | Baltim | | | | | | |
| Funeral | | Sex 7. Age | (In yrs. lest birt | | r 1 Year | If Under 24 Hrs | | Birth Dey, Yea | - | 9. Birthpt | ece (Stete or Foreign | |
| Director | 214-30-5130 Usuel Residence of Decedent | 1□M 217F 6 | 4 | Yrs. Months | Days | Hours Min. | June | 25, | 1935 | | yland | |
| show rd.st | 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | | | 10 | od. Inside City Limits | |
| 28a-f sho | MD Baltin | nore | Villa | Nova | | | | | | | 1 ☐ Yes ACXNo | |
| Dir. | 10e. Street and Number | | | | p Coda | | | | | Whet Count | iry? | |
| here 23a her must t | 4123 Bedford Ro | | | | 1207 | | 24 24 | | ISA | e - America | a la dia | |
| estral Examiner must be notified leted by Funeral Director | 11. Meritel Stetus 1 Never Merried ANMarried 3 Widowed 4 Divorced | 12. Wes Decedent Evarmed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | If Yes, spo | | Hispenic Origin? (S ean, Mexican, Puer Specify: | to Rican, etc. |) | | ck, White, e | etc. | |
| eted | 15. Decedent's 8 (Specify only highest gi | ducation ade completed) | 16e. | Decedent's Usi | uei Occup | petion during most of wa | orkina | 16b. | Kind of Bu | usiness/Ind | ustry | |
| Completed | Elemantary/Secondary (0-12) | College (1-4or 5+ | | Tife. DO NOT | use retire | od) | | | ay Ca | are Emplo | wo.d | |
| ŭ | 17. Father's Name (First, Middle, Las | 1) | | Day Cal | _ | 18. Mother's Na | ma (First, Mi | | | | yeu | |
| To Be C | Wallace M. Lawn | ence | | | | Alver | ta M. | Hanes | | | | |
| H | 19e. Informant's Name/Reletionship | | 19b. | . Mailing Addres | s (Street | t and Number or R | | | | Stata, Zip | Code) | |
| To | Joseph Marchand | - Hushand | 41 | 23 Redf | ord | Road, Vi | 11a No | m M | m 21 | 207 | | |
| 3 | 20a. Method of Disposition | | 20b. Pleca of | Disposition (Ne y, cremetory or | other nie | ne) | Dete | 20c. | Location - | City or To | wn, State | |
| once. | 12 ABurial 2 ☐ Cremetion 3 I 4 ☐ Donetion 5 ☐ Other (Spec | | | Haven | on to pio | | 2/8/20 | 00 G | len 1 | Burni | e. MD | |
| ouce. | 21. Signature of Funeret Service Licansee 22. Name end Address of Fecility Loring Byers Funeral Directors Inc. | | | | | | | | | | | |
| ă | Joseph Kellner 8728 Liberty Road, Randallstown, MD 21133 | | | | | | | | | | | |
| | 23a. Part1. Enter the diseese, or con shock, or heert failura. List only | | he deeth. Do r | not anter the mo | da of dyi | ing, such es cardia | c or respireto | ry errest, | OWILS. | 1 | Approximeta Intervet Between | |
| ian | | | | | | | | | | 1 | Onset and Deeth | |
| eal er | Immediete Causa (Finel diseese or condition | | eukeni | 4 | | | | | | | | |
| | resulting in deeth) | D. | ua to (or es e | consequenca of |): | | | | | i | | |
| - je | | b | | | | | | | | | | |
| Examiner | Sequentially list conditions, | D | ue to (or es a d | consequence of |): | | | | | | | |
| | Sequentially list conditions, it eny, leading to immediate cause. Enter Underfying Ceusa (Disaesa or injury that initieled evants Due to (or es a consequenca of): C | | | | | | | | | | | |
| edical | that initieted evants resulting In deeth) Lest | D | ue to (or es a c | onsequence of) | : | | | | | | | |
| | | d | | | | | | | | | | |
| Completed by Physician/N | Part II. Other significant conditions | contributing to death but | not resulting in | the underlying | cause gi | ven in Part I. | 23b. | Did tobace | co use co | ntribute to | the cause of death | |
| hy | | | | | | | | 1 Yes | 2 No | 3 Prob | ably Wunknow | |
| by F | - | | | | | | | | | | ` | |
| 2 | | | | | | | | Wes an au | | ave | ra autopsy findings ellable prior to | |
| 0 | | | | | - | | | | | of o | npietion of cause death? | |
| FO | | | | | | | | 1 □ Yes | 2 No | 1 🗆 | Yes 2□ No | |
| o Be Compl | 25. Was case rafarred to madical | | | | | 26. Plece of De | eth (Check o | nly one) | | | | |
| To | examiner? | Hospital: Inpatient | 2 □ ER/Ou | tpatient 3 D | OA OI | her: 4 Nursing I | Home 5 | Residence | 8 DOth | er (Specify | 1) | |
| Ë | 27. Menner of Death | 28a. Date of Injury (Month, Dey | | Tima of njury | 28c. Inju Wo | ry et | 28d. Desc | nibe how in | jury occur | red | | |
| atlo | Naturel 5 Pending Processing | n | | M | | Yes 2 No | | | | | | |
| edical Certification: | 3 Sulcide 6 Could not 4 Homicide datamined | 3 Sulcide 6 Could not be 28e Pleas of Injury - At home form street factory office 28f Location (Street and Number | | | | | | | oer or Rura | l Routa Number, | | |
| Medical Certification: To Be Com | 29e. Certifier Certifying P | nysician: To the bast of miner: On the besis of e and manner stete | xaminetion and | , daath occurrac d/or invastigatio | d at tha ti n, in my | ma, data and plac opinion, daath occ | a, and dua to urred at tha t | tha causa ma, data a | (s) and ma and place, | annar es st and dua to | eted. tha cause(s) | |
| M | 29b. Signature end title of certifier | | | 25 | c. Licen | se number | | 29d. C | Dete signe | d (Month, I | Dey, Year) | |
| 7 | Dennand Mille | - MD | | | DA | 7683 | | | 2/8/ | 00 | | |
| 1/ | 30. Name and address of person who | | ath (Item 23e) / | Type, Print) | | | | | , , | - | | |
| 10 | · · | 5 Mani Street | | | erste | thus M | D | | | | | |
| State | 31. Date-filed (Month, Dey, Yaar) | | | 200 R | 1 | * (* Will 1 | - | | | | | |
| egistrar | FEB 11 | 2000 De | 's Signeture | D' | 1000 | Kal | | | | | | |
| | | - | | 7 | - | | | | | | | |

| | de |
|---|----|
| State of Maryland / Department of Health and Mental Hygiene | |

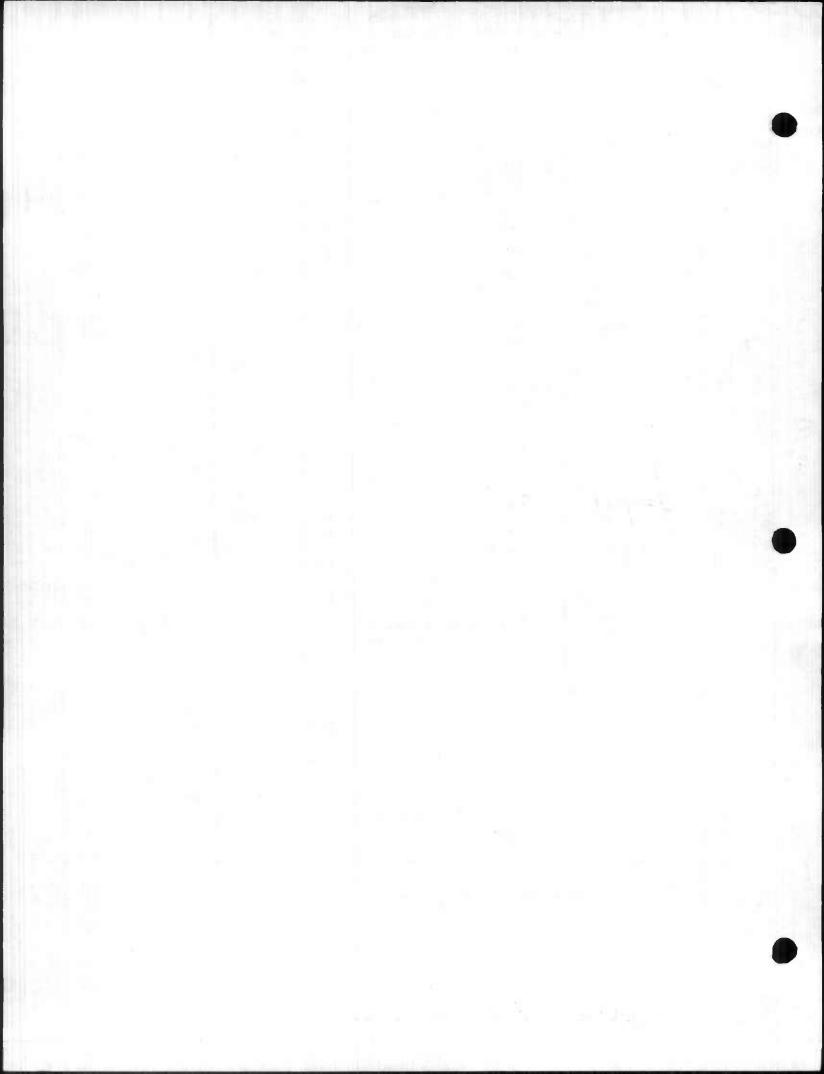
| | | | State of Maryland / Department of Health and N Certificate of Death | nemai m | Reg. No. | Q I | 1252 |
|---------------------|--|----------------|--|-----------------------|----------------------------------|------------|--|
| | Physicia | | Decedent's Name (First, Middle, Last) | 2. Dete of D Month | Dey | Year | 3. Time of Death |
| | · /Medic | ai | Delma Rose Muscatel | Feb. | 9, 20 | 000 | 6:30 AM |
| | Examin | er | 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Li | | | | |
| | | | 8700 Windsor Mill Road Windsor 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. | Mill 8. Dete of B | Balti | | lece (State or Foreign |
| | Funeral Director | | 014-03-9410 1 M 2 F 81 Yrs. Months Deys Hours Min. | (Month, D | ley, Yeer) | Mass | lace (Stete or Foreign try) achusettes |
| | pur * | | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location | | | 1 | 0d. Inside City Limits |
| | / sho | 20 | Maryland Baltimore Windsor Mill | | | | 1 ☐ Yes 2 🗓 No |
| | the the | Director | 10e, Street and Number 10f. Zip Code | | 10g. Citizen of W | het Coun | try? |
| | 3a or | | 8700 Windsor Mill 21244 | | U.S.A. | | |
| | death me 2 | Funeral | 11. Mentel Stetus 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispenic Origin? (Sp | pecify Yes or N | | | an Indien, |
| 020 | filed within 72 hours effer death with the Meryland Hygiene. ther than "natural", or thems 23s or 28s-f show int, the Meolical Expriment must be notified a | by Fu | Armed Forces? 1 Never Married 2 Married 1 Yes 2 No | Hican, etc.) | Spacific | White, | |
| 0 | "natural", | ted | 15. Decedent's Education 18e. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of work | kina | 16b. Kind of Bu | siness/Inc | Justry |
| 7 | within 7 ene. than "r | Completed | Elemantary/Secondery (0-12) College (1-4or 5+) | (III) | | | |
| 2 | filed with Hygiene. rther than | Co | 10 Years Beautician | | Self E | | yed |
| pu | | Be l | | | a, Meiden Sumeme | 9) | |
| Maryland 21215-0020 | | 2 | 18220 | Fournie | | 04-4- 7 | O- f-1 |
| Ma | 12 a a a a a a a a a a a a a a a a a a a | | 19a. Informent's Neme/Reletionship (Type, Print) Ms. Estelle Kleiner 19b. Mailing Address (Street end Number or Run 115 Pearl Street Mt. | | | | Code) |
| | Heeli Heeli ther | | 20e Method of Disposition 20b. Place of Disposition (Name of | Dete | NJ 080 | | wn, Stete |
| Baltimore, | | | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State cemetery, cremetory or other plece) | | | | |
| = | permit. Pages Department of Important: If it any Injury or page. | - | | /12/00 | Pikesvi | | MD |
| Ba | Dep dany | | Loring Byers Funer | | | | 0 |
| | | \dashv | 8728 Liberty Road 3a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart fellure. List only one cause on each line. | Randa or raspiratory | Listown, | MD | 21133 Approximate Interval Between |
| | Physician /Medical | | | | | | Onset and Deeth |
| | Examiner | | Immediata Causa (Final disease or condition resulting in death) e. Systemic Mastocytosi Dua to (or as a consequence of): | 2 | | | SMOS |
| | | ner | Dua to (or as a consequence or). | | | 1 | |
| | icete be executed physician end the burial-transit | Examiner | Sequentially list conditions. Due to (or es e consequenca of): | | | | |
| Ö, | e exe | Ē | Sequantially list conditions, if eny, leeding to immediata causa. Entar Underlying Cause (Disease or injury c. | | | | |
| 68760, | sete b shysic the b | dicai | that initieled events resulting in deeth) Lest Due to (or es e consequence of): | | | | |
| 9 × | | | d. | | | | |
| Вох | deeth certifi e ettending p od for use es | Physician/M | | | | | |
| o | the de | ysic | Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | _ | the cause of death? |
| σ. | thet dete | by P | Congestive Hear failure | 1 | Yes 25 No | 3 Pro | bebly 4 Unknown |
| rds, | | | | 24a. Wa | s an autopsy formed? | 24b. W | are autopsy findings allable prior to |
| | law requir | Set | MALNUTRITION | per | romed r | CO | mpletion of cause deeth? |
| | The law ete hes page 2 | Completed | | 1 🗆 | Yes 2□No | 10 | Yes 20 No |
| | certificete rector, pag | BeC | 25. Was case referred to medical 28. Place of Deal | th (Check only | one) | | |
| > | G 55 | 2 | exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho | ome 5- | sidence 6 Othe | r (Specif | y) |
| | After After fune | | 27. Mennar of Deeth 1 Natural 5 Panding 2 Accident investigation 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yas 2 No | 28d. Describe | how injury occurre | ed | |
| | or Attandi after death. Diractor: A I in by the f | Certification: | 3 Suicide 4 Homlcida 6 Could not be datarmined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) | | (Street end Numbe own, State) | er or Rure | I Route Number, |
| | | edical Co | 29a. Cartifier (Check only Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data end piece, and piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece, and piece to the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece, and the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece to the deeth occurred at the time, data end piece to the deeth occurred at the deeth occur | , and due to the | a ceuse(s) end mei | nner as s | lated. o the cause(s) |
| | Vithin 2 To the I complet | Z ed | one) end manner stated. 29b. Signature end title of certifier 29c. License number | | 29d. Dete signed | (Month | Dev. Year) |
| | 841 | - | D 2 tot 0 | > | 200. 2010 3101100 | | |
| | VIII | - | Lauren Spirit | | 2/11 | 12 | 000 |
| | IIV | | 30. Name and address of person who completel cause of death (Item 23a) (Type, Print) | 12. | to M |) 7 | 1202 |
| | Stat | e | 31. Dete (Month, Day, Year) 32. Registrar's Signature | 1-2-1 | | | |
| | Registra | | FFB 1 1 2000 Denver & Sparks | | | | |



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 2 5 3

| | | | Ce | rtificate of | Death | | Reg. No. | 0 9 2 0 0 | | | |
|---|---|---|---|---|------------------------------------|-------------------------|--|--|--|--|--|
| Dhoristan | 1. Decedent's Neme (First, Middle, Li | | | | | 2. Date of E | Death Day | 3. Time of Death | | | |
| Physician /Medical | Esther Eliz | abeth Mack | rey | | | FEBRUAR | | 2000 2:39 PM | | | |
| Examiner | 4a Facility Name (If not Institution, gi Saint Joseph | | nter | | | , or Location of Dec | | y of Deeth Baltimore | | | |
| Funeral | 5. Social Security Number 6. | | rrs. last birthday) Yrs. | If Under 1 Yea Months Days | r If Under 24 | | | Birthplace (State or Foreig Country) MD | | | |
| Director | Usual Residence of Decedent | | | | | 04-00 | 2-1/ | FILI | | | |
| Maryland of show fled at | 10e. State 10b. County MD NA | | City, Town or Lo | | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No | | | |
| ath with the Maryla 23s or 28s-f show ust be notified at ral Director | 10a. Street and Number 3922 Dolfield | Avenue | | 101. Zip Code 212. | | | | What Country? JSA | | | |
| Harra Harra Iner.m | 11. Marital Status 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: | | Was Decedent of If Yes, specify Cu | | | ice - American Indian, ack, White, atc. | | | | |
| L Z1Z15-0 ed within 72 ho spiene. wer than 'neturn ft, the Medical. | 15. Decedent's E (Specify only highest gr | ade completed) | 16a. Dece (Give | dent's Usuel Occu kind of work done DO NOT use retin | upation e during most of ed) | working | | Business/Industry | | | |
| led with hygiene, her than it, the M | Elementery/Secondery (0-12) 12th Grade | Cotlege (1-4or 5+) 3yrs. | | rvisor | | | Intell | igent Agency | | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hoglene. T is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F | 17. Father's Name (First, Middle, Last George | Henry | | | Matt | Neme (First, Midd ie | Banta | | | | |
| | 19e. informent's Neme/Relationship | У | 3922 | Dolfi | | | | n, State, Zip Code) 21215 e , Maryland | | | |
| Saltimore, emit. Pages 1 a spariment of Hea mportant: If Nem ny injury er othe nos. | 20a. Method of Disposition 1 Burtal 2 Cremation 3 Donation 5 Other (Speci | Removal from Stete | Pk. Ce | Cem Dete 20c. Location - City or Town, State Cem 02-10-2000 Arbutus, MD | | | | | | | |
| Balti permit. Departe Imports any Inju | 2) Signature of Funerel Service Lice | al track | | 2. Neme and Addi | | | | aryland 21202 Avenue | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in deeth) | FINEUMONI | | | ring, such es ca | rdiac or respiretory | arrest, | Approximate Intervet Between Onset end Deeth 10 DAYS | | | |
| executed n and lateransit | | SEPSIS | | | | | | 10 DAYS | | | |
| death certificate be executed to a second of continuous and for use as the burial-transit sician/Medical Examir | | | | | | | | | | | |
| . 0 | Pert II. Other significant conditions of | dcontributing to deeth but not | tributing to deeth but not resulting in the underlying cause given in Part t. | | | | | ontribute to the causa of death | | | |
| ires that the signed by the d be detached by the detached by the detached by the d by Phys | | | | | | 10 | Yes 20 No | 3 Probably 4 Unknow | | | |
| aw requ | | | | | | 24a. Wa | as an autopsy formed? | 24b. Were autopsy findings available prior to completion of cause of death? | | | |
| - F ad O | | | | | | 18 | Yes 2 No | 1 □ Yes 20 No | | | |
| yaician: The yaician: The secrificate director, pag | 25. Was case referred to medical examiner? | | | | | Death (Check only | one) | | | | |
| T SE T | 1 Yes 2 No | | 28b. Time of | II 3LI DOA | | ng Home 5 ☐ Re | | | | | |
| bending leath. tor: After the fune | 27. Menger of Death 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 0.0 | | 28d. Describe how injury occurred | | | | | | | |
| Ital or At its after o al Direct led in by | 3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Richard City or Town, State) | | | | | | | | | | |
| To the Hospital or At within Z4 hours after of To the Funeral Direct completely filled in by Medical Certiff | 29e. Certifier (Check only one) 1º Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| To the comple | 255. Edding in the second | | | | | | | 9d. Date signed (Month, Day, Year) | | | |
| 10/16 | P — / | 1 | | | 612 | | 2/7/2000 | | | | |
| 18/1 | 30. Name and address of parson who MOHAMED ALABRA | | | Print) SLER DR | IVE TO | WSON, M | IARYLAN | D 21204 | | | |
| State Registrar | 31. Date filed (Month, Dey, Year) FFR 1 1 2000 | ,32. Registrer's Sig | | lower | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month **Physician** McWilliams Gordon 1. February 4 2000 attor of Death 4c. County of Death 2000 2:00 P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Baltimore 7. Age (In yrs. last birthday) If Under 1 Months Rose da le r If Under 24 Hrs. 8. Date Hours Min. (Mo 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** Days 1♥ M 2□ F 216-07-7685 86 Director May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore Baltimore 1 Yes 2 No Maryland Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21234 9503 Orbitan Court U.S.A. Norms 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White. 'natural', or 1 Yes 2 No Specify: Specify à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Paper Box Company 12th Grade Cost Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 and 2 should be ealth and Mental Andrew McWilliams Anna Wohley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is ony injury or other tra page. 77 Open Gate Ct., Baltimore, MD 21236 Mrs. Carole Zablocki (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 1 Burial 2 Cremation 3 Removal from State 12/12/00 Baltimore, Maryland 4 Donation 5 Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mark 9705 Belair Rd., BAltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Lat only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Massive gastrointestinal hemorrhage from /Medical Immediate Cause (Final disease or condition resulting in death) a duodenal ulcer Examiner Due to (or as a consequence of) Examiner ician and buriel-transit The lew requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel Box 68760. Physician/Medical Due to (or as a consequence of): US0 88 signed by the a d be detached f P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of death? page 2 : 1 Yes 1 Yes 2 No 2 No Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient 2 2 ER/Outpatient 3 DOA 1 **Inneral** 27. Manner of Death 1 (DNatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attends - within 24 hours after death - To the Funeral Director: A compasse Illed in by the ti 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide

ewilliam, bordon

State Registrar

Medical

29a. Certifier

(Check only one)

Stuart R.

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

FEB

DHMH 16 Rev 6/95

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D36663

9000 Franklin Square Drive Baltimore, mo 21237

29d. Date signed (Month, Day, Year)

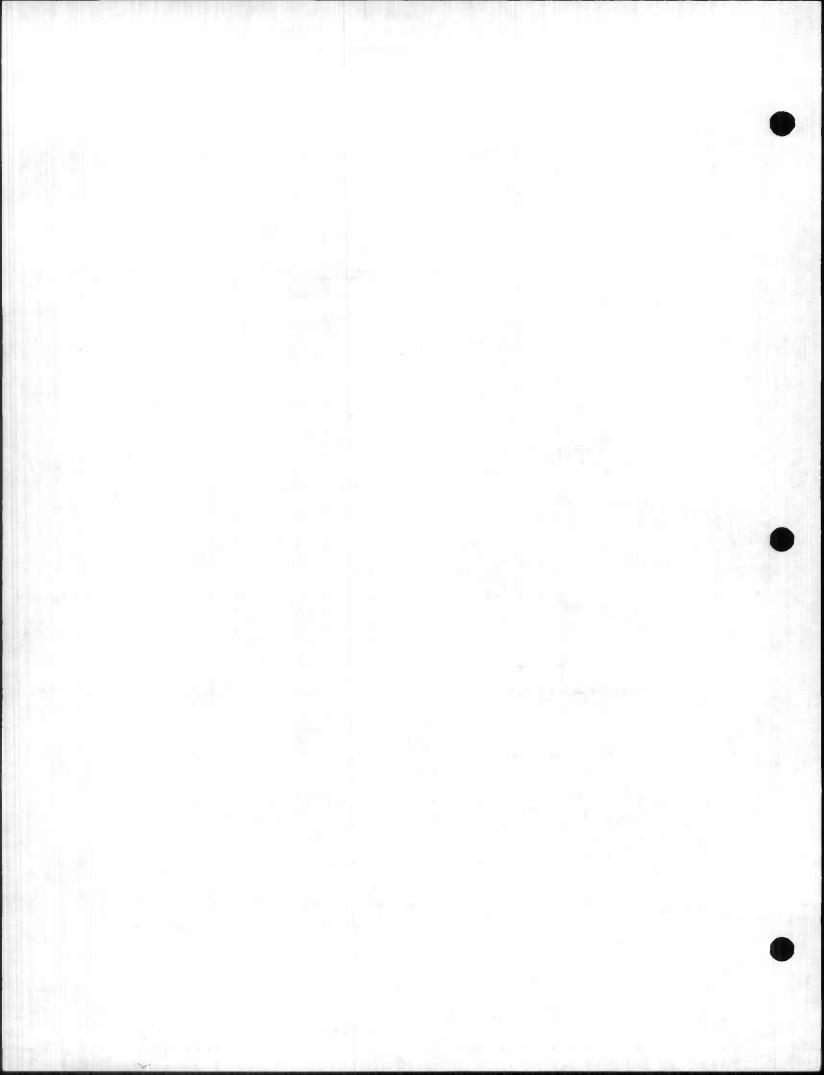
1 Sleell

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

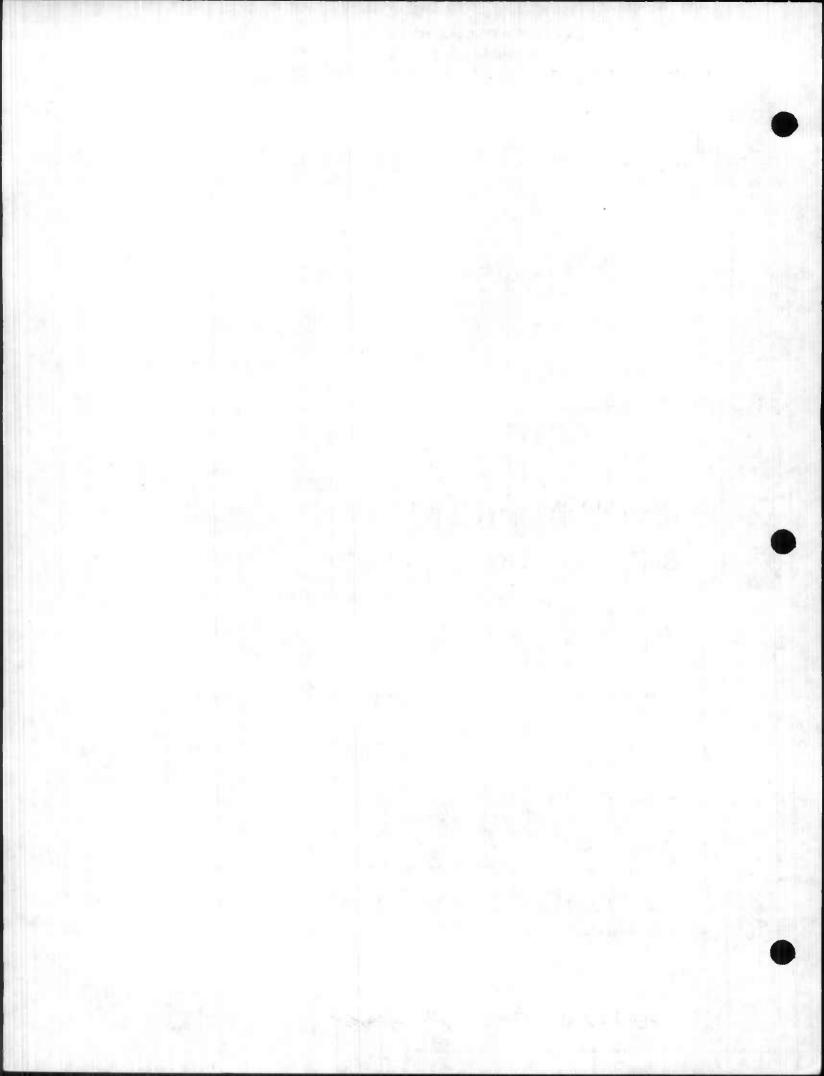
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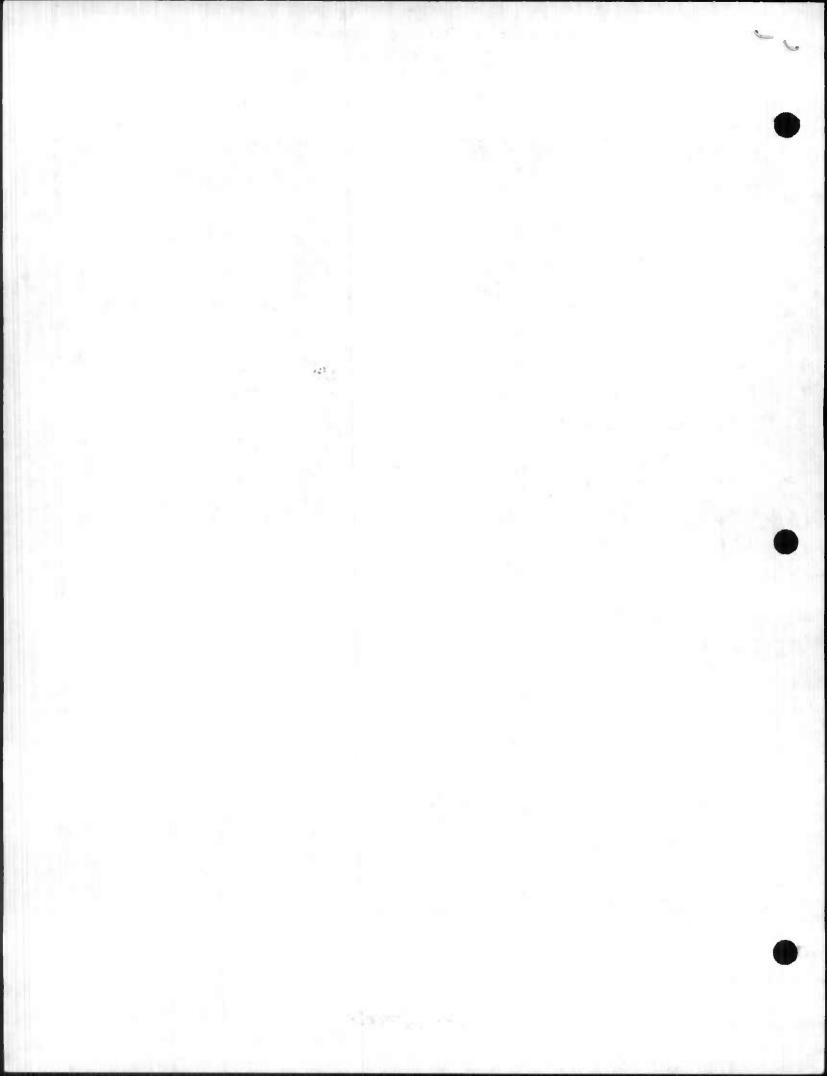
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|--|--|--|--|--|------------------|--|--|--|--|--|--|-------------------------------|--|---|--|--|--|
| an cal | RO | SEN | MR | 1 | | | | | MII | LLE | R | FE | Month BRUAR | | | 11:157 | |
| eral ctor | THE | | not institution HOPK umber 16 | INS 6. Se | HOSE | 7. Age | (In yrs. k | est <i>birthdey)</i> Yrs. | If Under | er 1 Yaar | | RE CI | | Year) | 9. Birth | h hpiaca (Stete or F unitry) yland | |
| | Usuel Ra | asidence of | Decedant 10b. County | v | | | | , Town or Lo | cation | | | | | | | 10d. Inside City | |
| | | land | Balt | | re | | | ansdow | | | | | | | | 1 ☐ Yes 2 | |
| | | et and Num | | CINO | | | | 10f. Zip Code | | | | | | g. Citizen of | f What Cou | untry? | |
| | - | | zel Av | venu | | | | 1 | | | 227 | | | | | tates | |
| | 101 | | ed 223 Mar | | Armed 1 D Yes | Decedent Ed Forces? es 2 🔯 No Give or Detes: | | | If Yes, sp | pecify Cub | Hispanic Origin? ben, Mexican, Pu Specify: | (Specify) Jarto Ricar | res or No- n, etc.) | BI | aca - Amer ack, White | | |
| | Eleme | (Speci | 15. Deceder ify only highe ndary (0-12) | nt's Edu | a complet | ed) ge (1-4or 5+ | +) | 16a. Deced (Give life. L | kind of w DO NOT | vork done use retire | 1 | 16b. Kind of | | | | | |
| - | 17. Fath | ar's Nema (i | 12 First, Middle, | , Last) | | | | Aucti | .Onee | | 18. Mother's I | Neme (Fir | st, Middle, M | | Self Employed | | |
| To Be | Th | nomas | James | Woo | ds, | Jr. | | | | | Effi | c Pea | r1 Ch | ance | | | |
| | | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, | | | | | | | | | | | | wn, State, Zip Code) | | | |
| | Jacob B. Miller (Husband) 135 Hazel Avenue Lansdowne, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Neme of Dete 20c. Location - City or Town, Stata | | | | | | | | | | | | Town, Stata | | | | |
| | 1 52 | Burial 2 | Cremation | | | om Stete | | metery, cren w Cat1 | | _ | | | | | | | |
| | | 4 Donation 5 Other (Specify) New Cathedral Cemetery 2/11/00 Baltimore, MD 21. Signature of Funerel Service Licental Ambrose Funeral Home of Lansdowne | | | | | | | | | | | | | | | |
| | 1 | 3/10 | man | M | 1711 | uh | | AI | | | merar r | TOILLE | or har | | | | |
| | 23a Pe | | | VI | 1 1 | -11 | MS | PY 27 | 719 1 | Hammo | onds Fer | ry R | oad La | ansdow | ne, M | (D) 21227 | |
| | | | | or complet only o | ticetions(th | et caused ton each line | the deeth | o not ent | 719 I | Hammo ode of dy | onds Fer | cry R | oad La piratory arre | ansdow est, | ne, M | Approximete Intervet Betwee Onset and Da | |
| | Immedia | ate Cause (for conditions of the conditions of t | Final | or complete only of | lications(th | time | 24 | Jo not ent | er the mo | ctio | Ing, such es care | cry R | oad La | ansdow est, | ne, M | Approximete tntervet Betwe | |
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| | Immedia disease resulting Sequentif any, le cause, Cause (thet initiate resulting | ate Cause (f or condition g in death) tially list con eading to imi Enter Under Disease or i eted events g in death) L | Final n inditions, mediate riving injury | { | b | Yax: | Q y Due to (or Due to (or Due to (or | as e consequence as a c | quenca of quenca of | ction | Ing, such es card | diec or res | piratory arre | bacco usa c | contributs | Approximete tntervet Betwe | |
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| | /Medic | | FRANCES | | Lia | | T | FIBR | | 1000 | 13:30 A.M | |
| | Examir | ner | 4a Facility Name (If not institution, give | street and number) | | | | or Location of Dea | 11 | | 0.0 | |
| | | | 200 Kimar | | Vai | 731 | er 1 Year If Under 24 | | | RFO | | |
| н | Funeral | M | 5. Social Security Number 6. So | □M 25€F · · | last birthday Yrs. | Month | | Vin. (Month, L | | | lace (State or Foreign try) | |
| | Director | | Usual Residence of Decedent | 68 | 110. | | | 13U | 3,1931 | VIK | GINIA | |
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| | 72 hours after death with the Maryland naturel; or items 23s or 28s-f show diest Essember must be notified at | Funeral | 200 Kimary L | 12. Was Decedent Ever in U | 30 | Was Dec | 21050 | ? (Specify Yes or I | lo- 14. Race | - America | an Indian. | |
| | Per d | 5 | 1 ☐ Never Married 2 ☐ Married | Armed Forcea? 1 ☐ Yes 2≅ No | , | If Yes, sp | edent of Hispanic Origin ecify Cuban, Mexican, P | uerto Ricen, etc.) | Black | k, White, | | |
| 20 | rs aft | by | 35€ Widowed 4 □ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes | 2 No Specify: | | Specify. | LITT | 77. | |
| 21215-0020 | n 72 hours "naturel", | B | 15. Decedent's Ed | | 18a Dece | edent's Us | ual Occupation | | 16b. Kind of Bu | siness/Inc | dustry | |
| 15 | | Completed | (Specify only highest grades) | de completed) | (Give | e kind of v | ork done during most of use retired) | working | | | | |
| 212 | filed within Hygiene. ther than " ent, the Me | E O | Elementary/Secondary (0-12) | College (1-4or 5+) | 77 | 485 | TARY | | FOREST | 6.H. | 1 BACK | |
| D | Hygid other | Be C | 17. Father's Name (First, Middle, Last) | | | alank North | | Name (First, Midd | le, Maiden Sumam | | | |
| Maryland | A S D | To B | Fielde C | 7. WARD | | | No | omi s | TOO | 0 | | |
| ary | | - | 19a. Informant'a Name/Relationship (7 | | 19b. Mail | ling Addre | sa (Street and Number of | | ber, City or Town, | State, Zip | Code) 21111 | |
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| ē, | - i 5 5 | | 20a. Method of Disposition | 20b. I | Place of Diap | osition (N | ame of | Date | 20c. Location - | City or To | wn, State | |
| altimore, | Pagas net of I nrt: If its iry or o | | 1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify | Hemoval from State | 0- 0 | amatory of | other place) | FEG. 9, | A Or (| 0 | ARYLAND | |
| | | | 21. Signiture of Funeral Service Licent | 0 03 | THIE | 2 Name | and Address of Facility | | BURIT | 10 | ^ | |
| Ba | permit. Departr Importa any Inji | | 2.50 | | 2 | YAC | 4 FURRAL | -TEGAH; | -125T HILL | 5.6. | A. AIGSO | |
| _ | | | Chapt AC | Joh . | 3 | 3151 | NO TROGU | Rive For | 11/4 TUS | 71 | 1ARYLAND | |
| No. | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | plicetions that ceused the deat one ceuse on each line. | th. Do not er | nter the m | ode of dying, such as ce | rdiac or respiratory | arrest, | l i | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | Immediate Course (Fine) | V | | | | | | | | |
| | Examiner | | Immediate Cause (Final disease or condition resulting in death) | 1 | 37cme | | | | | | | |
| | | 10 | | a. LUNG Due to (| or as a conse | equence o | f): | | | 1 | | |
| | ted nsit | Examiner | | b | | | | | | | | |
| | ficate be executed physician and is the bunal-transit | Ха | Sequentially list conditiona, if any, leading to immediate ceuse. Enter Underlying | Due to (d | 1 | | | | | | | |
| 68760, | cata be e physician the buria | | Cause (Disease or injury that initiated events | C | | | | | | | | |
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| | eath certific attending p | 3 | d | | | | | | | | | |
| Вох | death certi | Physician/M | | | | | | | | | | |
| o | the d | ys | Part II. Other significant conditions co | intributing to death but not res | underlying | | 23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4 | | | | | |
| 0 | that dat dat | | | | | | | | Yes 2 No | 3 Prot | bably 42 Unknown | |
| Records, | requires hear sign | d by | | | | | | 24a. W | as an autopsy | | ere autopay findinga | |
| Ö | | ete | | | | | | ре | rformed? | co | allable prior to mpletion of ceuse | |
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| 8 | cate he | | | | | | | 10 | Yea 🗷 No | 1 [| Yes 2 No | |
| Vital | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othor | Death (Check on) | | | | |
| 0 | E 10 T3 | 5 | 1 ☐ Yes 25Q No 27. Manner of Death | 28a. Date of Injury | ER/Outpation | | DOA 4 Nursi | | sidence 6 Other | | y) | |
| | | lo | 1 Natural 5 ☐ Pending | (Month, Day Year) | Injury | М | 28c. Injury at Work? 1 ☐ Yea 2 ☐ No | | o now injury occur | 00 | | |
| 2 | Attending or death. ector: Atta by the tune | cat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | ome form o | | | | (Street and Numb | er or Rum | J Route Number | |
| Division | or A Direction by | Certification: | 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Special | fy) | ileei, laci | ory, omce | City or 1 | own, State) | 0, 0, 110,0 | | |
| | president of the second of the | | 29a, Certifier TSC Certifying Phy | valelan. To the best of my kee | udadaa daa | th annuar | d at the time, date and r | less and due to the | o seuso(s) and ma | nnor ec el | tetod | |
| | To the Hespital or Attent within 24 hours after deatl To the Funeral Director: completely tilled in by the | edicai | | relcian: To the best of my kno iner: On the basis of examina and manner stated. | | | | | | | | |
| | thin the | Me | 29b. Signature and title of certifier | and manner states. | | 2 | 9c. License number | | 29d. Date signed | d (Month. | Day, Year) | |
| | 5 7 ¥ 5 9 | | 1 1 10 | | 29d. Date signed (Month, Day, Year) | | | | | | | |
| | | | your Me | villagele | (M) | | D220(| | FEBRUA | 167 8 | 3,9000 | |
| | 0 | ŀ | 30. Name and eddress of person who o | completed ceuse of death (Iter | | - / | D330(1) | 0 . 0 | 11 - 1 | Maar | 100 | |
| | | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | 461 | HERY I MY | NORU I | YOUNTON, | THY | とものし | |
| | ° Sta Registr | _ | EED 1 1 2000 | Server & | 1. 1 | na W | 1 | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day 9,2000 6:29A.M tion of Death 4s County of Death RUTH BIEN MILLER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Square Hospital Cer er 6. Sex 7. Age (In yrs. last birthday) enter Cosedale If Under 24 Hrs. 8. Date 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 80 JUNE 13, 1919 213-14-5046 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BAUTIMORE MD. PARKVILLE 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? SS 10 WALTHER BLVD. # 1228 21234 U.S. A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SECRETARY ESTATE UNKNOWN PEAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) LOUISE BIEN PUZICKA WALTER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY H. MILLER, SPOUSE PARKVILLE MD. 21234 20c. Location - City or Town, State 8810 WANTHER BLVD. # 1228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date FEB 12, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PHRKWOOD COMETERY 2000 PARKVILLE, MO 22. Name and Address of Facility EVAN'S FUNERM CITAPEL 21. Signature el Funeral Service Licens 8500 HARFORD RD. PARKVILLE ,MD. 21234 23a. Part3 Enter the disease shock, or heart failure. fillions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 10 Due to (or as a cor Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

icien and buriel-transit The lew requires that the death certificate be executed physicien s the buriel P.O. Box 68760. 80 signed by the Records, Division of Vital or Attending Physician; funeral director, After this 24 hours efter death.

Physician /Medical

Examiner

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

deeth with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Manylan Department of Health and Mentel Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show any Injury or other treumatic event, the Medical Examinations in an indired at

aitimore, Maryland 21215-0020

Medical within 24 hor To the Fune completely fi State Registrar

filled in by

Hospital

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25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be 3 Suicide 4 I Homicide

29a. Certifier

FEB

(Check only one)

5 Pending investigation

28a. Dete of Injury (Month, Day Year) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State)

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier

025569 STE. 24

29c. License number

29d. Date signed (Month, Day, Year)

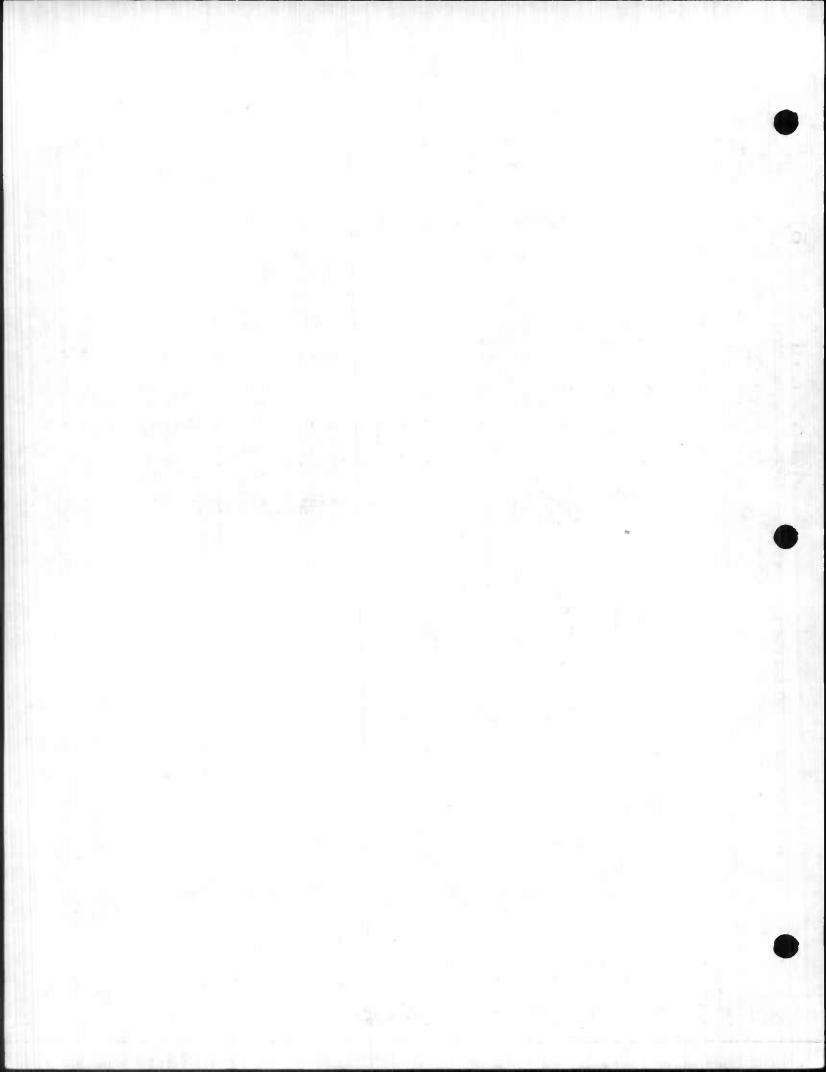
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1205 YORK RD. MD. FRANCIS WETGMAN

MUNIONI

MO. 21093

31. Date filed (Month, Day, Year) 1 1

32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 4c. County of Death 4:45 PM liam 2000 Februar 4b. City, Town, or Location of Death / 4a Facility Name (If not Institution, give street end number, if Under 24 Hrs. 8. Date of Birth (Morth, Day, Year) Hospita Nor (enter Baltimore thwest If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Days 12M 2□ F 215-05-4016 88 05 12 Md Usuei Residenca of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No Howard Marriotsville 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 12105 Old Frederick Road 21104 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece · American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married White 1 Yes 2 No Specify: 3 ☐ Widowed 4 🐼 Qivorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Supply Officer Md. St. Police 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Samuel Maslin Fannie Godwin 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zlp Code) Arrington Rd. Marriotsville, Md 21104
sition (Neme of Dete 20c. Location - City of Town, Stete Frank Enos/nephew 1701 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Dother (Specify) Entomb Crestlawn 02 12 Marriotsville, Md 22. Name end Address of Fecility 21. Signature of Funeral Servica Licansee Sterling Ashton Schwab Funeral Home, Inc Ry bus Jodach 736 Edmondson Avenue, Balto, Md. 21228 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in death) perforated Viscus Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequença of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown PERTENSION 24b. Were sutopsy findings availeble prior to completion of cause of death? 24e. Was en eutopsy performed? PERIPHERAL VASCULAR DISEASE POLYCYTHEMIA

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

Madical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartified 14. S. RAO. MO 9,5000

P.O. Box 68760 Division of Vital Records, Attanding Physician: ŏ 24 hours a

Physician

/Medical

Examiner

Directo

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Funeral

Director

item 27 is marked other than "natural", or items 23a or other traumatic avent, the Modical Exercises must be a

permit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or ferma 23a any Injury or other traumatic avent, the Medical Experimentages.

Physician

/Medical **Examiner**

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Certification: To

Medical

altimore, Maryland 21215-0020

with the Maryland r 28a-f show

State Registrar

MORTHWEST 31. Date filed (Month, Day, Yeer) FEB 1 1 2000

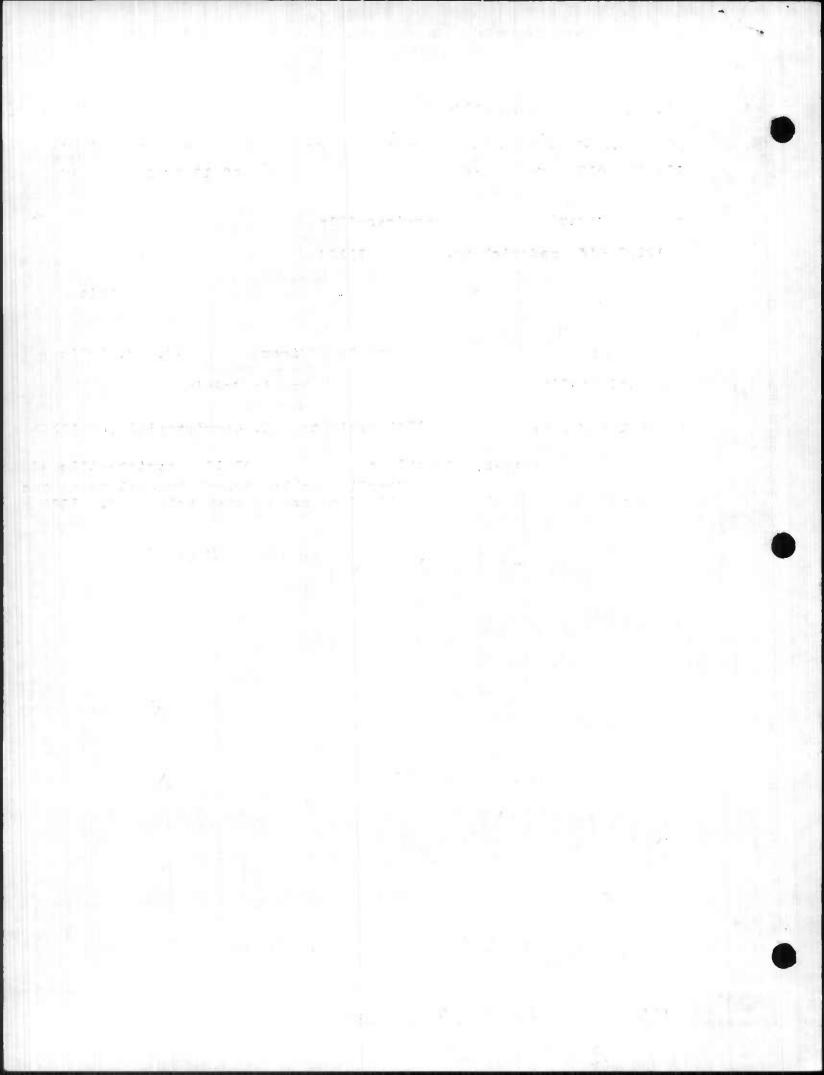
30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

HOSPITAL CENTER , RANDALLSTOWN 32. Registrer's Signature

043462

K.S.RAO.XD

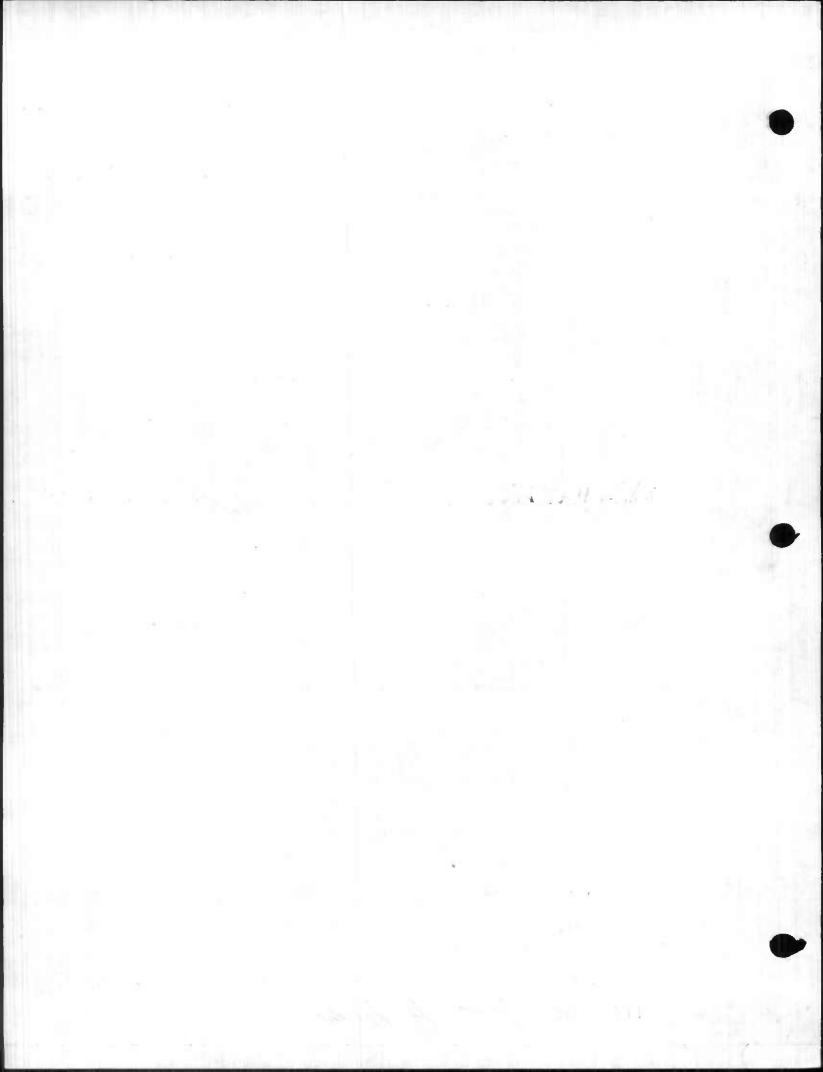
REBRUAR.



DHMH 16 Rev 6/95

| | | | State of Marylan | • | nt of Healtl te of Dea | | Hygiene Reg. No. | 0 04259 | | | |
|---------------------|--|--|---|------------------------------|--|--|---------------------------------|--|--|--|--|
| | Physician /Medical | 1. Decedent's Name (First, Middle, Last, Clifford L. | Meisenhal | der | | Mont | of Death h Dey RUARY 06,2 | 3. Time of Death Year 000 8:45 P.M. | | | |
| | Examiner | 4e Facility Neme (If not institution, give VAMHCS FOPT HOWARD | | | | Town, or Location of | | y of Death | | | |
| | Funeral Director | 77) TH OLAS | 7. Age (In yrs. 1 | Yrs. If Und | | | th, Day, Year) | 9. Birthpiace (Stete or Foreign Country) Balto.Md | | | |
| | r 28a-f ahow notified at irector | Usual Residence of Decedent 10a. State 10b. County Md. BAlti | | y, Town or Location | | • | | 10d. Inside City Limits 1 ☐ Yas 2 ☑ No | | | |
| | offer death with the Me of theme 23s or 28s-4 so other must be notified Funeral Director | 10a. Street and Number 7407 Dunmanway | | | ip Code 21222 | | 10g. Citizen of | What Country? | | | |
| 020 | by by | | 12. Was Decedent Ever in U, Armed Forces? 1 ☐Yes 2 ☐ No N a V | If Yes, sp | edent of Hispanic ecity Cuban, Mex 2 X No Spec | Origin? (Specify Yes ican, Puerto Rican, et cify: | or No- c.) 14. Ra | ce-American Indian, ock, White, etc. | | | |
| Maryland 21215-0020 | ygiene. Net than *natural*, the Medical Exact. Completed by | 15. Decedent's Edu (Specify only highest grade Elementery/Secondery (0-12) | cation | 16a Decedent's Hs | rork done during n use retired) | | | Business/Industry | | | |
| yland | W voit | 17. Father's Neme (First, Middle, Last) John Meisenhal | | | 18. Mc | other's Neme (First, Norothy Sc | liddle, Maiden Sumer | | | | |
| | f Heelth of Heel | 19a. Informent's Neme/Reletionship (Ty Lilah Meisenha 20a. Method of Disposition | lder/Wife | 7407 I | unmanwa | ay, Dunda | | | | | |
| Baltimore, | permit. Peges Department of Important: If fit any injury or o | 1 Buriel 2 Tremetion 3 FR 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licens | Ba | 22 Name Bradl | and Address of Fa | ton-Mattl | news Fund | eral Home,Inc | | | |
| P | hysician /Medical | 23a. Pert1. Enter the disease, or complishock, or heart feiture. List only or Immediate Cause (Finel disease or condition | cetions that caused the death he cause on each line. | . Do not enter the me | ode of dying, such | es cardiac or respiral | Rd., Balte ory arrest, | Approximate Intervel Between Onset and Death | | | |
| | m and inal-transit Examiner | resulting In death) | Due to (or | r es e consequence o | ·): | | | | | | |
| 9 x c | cate be the bu | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest | Due to (or Due to (or | | | | | | | | |
| m ; | e ette ed for | Part II. Other significant conditions con | tributing to death but not resu | art I. 23b | Did tobacco use co | ontribute to the cause of death? 3 Probably 4 Unknown | | | | | |
| ords, | been sign should be | | | | | 24a. | Wes en eutopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? | | | |
| ital Re | ystem. The lay director, page 2 | 25. Was case referred to medical | | | 26 P | lace of Deeth (Check | 1 ☐ Yes 2 ☐ No | 1 Yes 2 No | | | |
| vision of Vital | after deeth. Director: After this cer in by the funeral direc | examiner? 1 Yes 2 No 27. Menner of Death Naturel 5 Panding Accident investigation | ospitel: 1 inpatient 2 28a. Dete of Injury (Month, Dey Year) | ER/Outpatient 3 [| Other | Nursing Home 5 28d. Des | | | | | |
| 7 | within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At ho building, etc. (Specify | ·) | | City | or Town, Stete) | ber or Rural Route Number, | | | |
| 3 | within 24 hours To the Funeral completely filled | (Check only one) 2 Medical Examir | ician: To the best of my knowner: On the basis of examinet and manner stated. | ion end/or investigation | n, in my opinion, (| deeth occurred at the | time, date end plece, | , and due to the cause(s) | | | |
|) | Toro | 29b. Signature and title of certifier | h | 2 | 9c. License numb | 9 <u>S</u> | h I | od (Month, Dey, Year) | | | |
| | 5 | 30. Name and address of person who co DR SURESH SHANDELLY/ | mpleted cause of death (Item | 23e) (Type, Print) NORTH POI | T ROAD, | FORT HOVA | RD, MARYLA | AND 21052 | | | |
| | State Registrar | 31. Date filed (Month, Day, Year) FFR 1 1 2000 | 32. Registrer's Signet | ure & la | 2. 10 3 | | | | | | |

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. t's Name (First, Middla, Last) 2. Deta of Deeth Month Day Year Physician 2000 EBRUAR /Medical Facility Name (If not institution, give street and number) 4b. City, Town/og/Location of Death 4c. County of Death Examiner BACTA If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1₽M 2□F Hours 214-30-4201 13,1922 Italy Director Usual Residence of Decedent the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or flams 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at Baltimore Dunda1k 1 Yes 2 No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 225 Riverview Ave. U.S.A. deeth v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or han any injury or other treumatic event, the Med and Espans Bleck, White, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify: White P 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Bricklayer Unk 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Unk Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28104 19a. Informant's Name/Relationship (Type, Print) 3032 Rockridge Pass, Matthews, N.C. Rosemarie Loiacono/Daughter 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto., Md. 2-8-00 St. Stanislaus Cemt 21. Signature of Funeral Service Licenses 22, Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical TICULA Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 087 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably Wunknown 0 Records, g 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s hes 1 Yes 25 No 1 □ Yas 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitet 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Yes 2 ☐ No this funeral 27. Manner of Death 28b. Time of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After 5 Pending investigation Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and manner as attated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Ligense number 29d. Data signed (Month, Day, Year) 30. Name/and address of person who completed cause of death (Item 23s) (Type, Print) 712212 ARROL 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 1 Registrar parks

ORIGINAL

and the first

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | Certii | ficate | of. | Death | | | Reg. No. | UU | 046 | 01 |
|----------------------------|--|------------------|--|---|--------------------------|------------------------|-----------|----------------------------------|--------------|---|-------------------------|---|---|-------------------------|--|----------------|
| | Physic | - | 1. Decedent's Nama (First, Mid | dla, Last) | | | | | | | | 2. Date of D | eath Day | Yaar | 3. Time o | |
| 2 | /Medi | | Harry M. | Menge | rs | | | | | | | Febru | ely 1, | 2000 | 001 | 11 |
| | Examir | ner | 4a. Fecility Name (If not instituti St. Agnes H | | um <i>ber)</i> | | | | 1 | | | cation of Dea | | ity of Death | | |
| | | | | - | - A | - I - A film | 4 . 1 h | f Undar 1 | Voor | Bal 1 | | | N/F | | | |
| | Funeral Director | | 5. Social Security Number 2 1 4 - 0 3 - 6 4 0 5 | 6. Sex 1. M 2 □ F | 7. Age (II | n yrs. last birti Y | ruely/ | | Days | Hours | Min. | 8. Dete of B (Month, D | irth Pay, Year) | 9. Birth | placa (Stata intry) Md | or Foreign |
| | the Maryland 7 28a-f ehow | | Usual Rasidance of Decedant 10a. Stata 10b. Count | v | 10 | c. City, Town | or Locati | ion | | | | | | т | 10d. Inside C | the Limite |
| | | | Md Baltimore | | | | onsv | | е | | | | | | | 2 RNo |
| | th with th 23a or 28 | Funeral Director | 10e. Street and Number 1 Summit Hi | ll Ct. A | pt C | | | 10f. Zip C | 122 | 28 | | | 10g. Citizan o | Whet Cou | intry? | |
| 020 | efter dee or items | by | 11. Marital Status 1 Navar Married 2 Ma 3 Widowed 4 Divorce | 12. Wes Dec Armed F 1 Yas If Yas, G Yaer or I | orcas? 2 No iva | r in U,S. | If Ya | as, specif | y Cuba | lispanic Ori an, Maxicar Specify: | n, Puarto | ecify Yas or N Rican, atc.) | fy Yas or No- can, atc.) 14. Race - An Black, Wt Specify: | | | |
| 20 | oe filed within 72 sel Hygiena. Jother than "nai | ted | 15. Deceda | int's Education | 1 | 16a. | Decedani | t's Usuai | Occup | ation | t of work | ina | 16b. Kind of | | hite ndustry | |
| 21 | | nple | Elamantary/Secondary (0-12) | ast grada completed Collega | (1-4or 5+) | | lifa. DO | NOT usa | retire | during mos d) | t or work | ing | | | | |
| 21 | | Co | 12 | | | C | ommi | ssi | on | Merc | | | | vest | ock | |
| and | | Be | 17. Fathar's Nama (First, Middle | | | | | | | | | | a, Maidan Sum | ima) | | |
| N N | | P | Harry Menge | | | | | | | | | McKe | | | | 000 |
| Ma | d 2 st th end 7 is n traun | | 19e. tnformant's Neme/Relation Isabelle Men | | fe | | | | | | | | ber, City or Tow • Cato | | | |
| | Healt Healt m 2 | | 20a. Mathod of Disposition | -3, | | 20b. Place of | | | | | | Date | 20c. Location | | | u |
| no | ages intof it: If h | | 1 Burial 2 □ Cramation 3 □ Ramoval from Stata cerr | | | | | atery, cramatory or other place) | | | | | | | | |
| Baltimore, | permit. Pages Department of Inportant: If ite eny injury or ot | | 21. Signatura of Funarel Sarvice | Wood. | oodlawn Cemetery 02 10 | | | | | | | Baltimore, Md. | | | | |
| Ba | Depa Impo eny I | | 1 | 1/1 | | | Ste | rli | ng. | -Asht | on- | | b Fune | | | |
| | | | 23a. Part1. Entar tha disaase shock, or haert feilura. | or complications that | caused the | daeth. Do n | 736 | Ed ha moda | m OI | ndsor | cardiac o | enue, | Balto | , Md | 2122 Approxima | 8 |
| | Physician | | shock, or haert feilura. | t only one cause on | eech lina. | | | | | | | , | | | Approxima Interval Ba Onsat and | tween Daath |
| и | /Medical | | immediata Cause (Finel | NAB | 1250 | o. anti | . (0 | rond | x e-u | · ()a | .C CA1 | 10- 0 | sease | i | | |
| | Examiner | | disaasa or condition rasulting in daath) | a. 14 17 | | a to (or as a c | | | | 9 | | | . 3 | | | |
| _ | D Æ | ner | | | | (0. 00 0 | | | | | | | | | | |
| | eeth certificate be executed ettanding physician and for use as the bunel-transit | Examiner | Sequentially list conditions, Dua to (or as a consequence of): | | | | | | | | | | | | | |
| 60, | oe exe | | Sequantially list conditions, if any, leeding to immadiate cause. Enter Undarlying Causa (Disaase or injury | | | | | | | | | | | 1 | | |
| 68760, | certificate be execut ding physician and use as the buriel-trar | edical | that initiated evants rasulting in deeth) Last Dua to (or es e consequence | | | | | | | nce of): | | | | | | |
| × 6 | ding | ∑ | | d | | | | | | | | | | i | | |
| Box | ettan for u | clar | | | | | | | | | | | | | | |
| P.O. | the deeth y the ettar ached for u | Physician/ | - | | | | | | | | | old tobacco use contributa to the cause of death? ☐ Yes 2☐ No 3☐ Probably 4월2Unknown | | | | |
| | that hed b | by Pi | congestiv | e Heart | Fa | ilure | ಲ | | | | | 1 | Yes 2 No | 3 Pro | орвону 4 | cunknown |
| Division of Vital Records, | v requires that the deeth cen been signed by the ettandin should be detached for use | Completed b | | | _ | | | | | | | 24a. Wa | s an autopsy formed? | 6 | Vara eutopsy vellable prior ompletion of | to |
| Re | hes ye 2 | dm | | | | | | | | | | | and. | | f death? | |
| a | | | 25. Was casa refarred to medic | ol . | | | | | | 00 01 | | | Yes 200 No | 1 | ☐ Yas 2 ☐ | MO |
| > | Physician: rthis cartific ral director, | To Be | examinar? | Hospital: | Inpatiant | 2 PER/Out | netient | 3□ DOA | Oth | 44. | | h <i>(Chack only</i> | ona) sidence 6 □ C | ther (Cner | its. | |
| 0 | g Phys ar this eral di | E | 27. Manner of Deeth | 28a. Data | of Injury oth, Day Ye | | ima of | | injur Wor | | | | how injury occ | | ny) | |
| 0 | ath. r: Aft | atio | Z C /TOOIOUITI | tigation | nn, Day re | <i>iar)</i> in | ijury | М | | Yas 2□ | No | | | | | |
| Divis | or Atte aftar de Directo I in by th | Certification: | Suicide Suicide Suici | | | | | | | | nber or Ru | ral Route Nur | nber, | | | |
| | To the Hospital or Attending Physician: within 24 hours affar death. To the Funeral Director: Affar this cartific completely filled in by the funeral director. | edical C | 29a. Certifiar (Check only one) 29 Medica | ng Physician: To the Examinar: On the b | pasis of axe | mination and | death oc | curred at | tha tir | na, date an pinion, dee | id place, oth occurr | and dua to the | a causa(s) and i | mannar as e, and due | stated. to the cause(| s) |
| | ithin ithe | Mec | 29b. Signature and file of certific | 2.1 | nnar statad | | | 29c. | Licans | a number | | | 29d. Data sign | ned (Month | Dev. Year) | |
| | F 3 F 8 | | 5 h lm | NHO | V | | | | | | | | | | | 10 |
| | | - | 30 Name and address of second | * * O | | (lter oc-) C | Tume De | | H | 2 8 + | 91 | 15 | Februa | 1 + | 1 200 | |
| | 2 | | 30. Nama and addrass of person | ensselte | sa of deatr | (Hern 238) (| Type, Phr | cato | n | Aven | ne | , Balti | more . | an | | |
| | Sta | te | 31. Data filed (Month, Day, Year | 7) 32.1 | Ragistrar's | Signature | | | | | - | | | | | |
| | Registr | - T | FEB 1 1 20 | no So | | 1. | | , | | | | | | | | |
| DH | MH 16 Ray 6/9 | 5 | 20 | 00 | | B. | ple | ack. | A Partie | | | | _ | | | |
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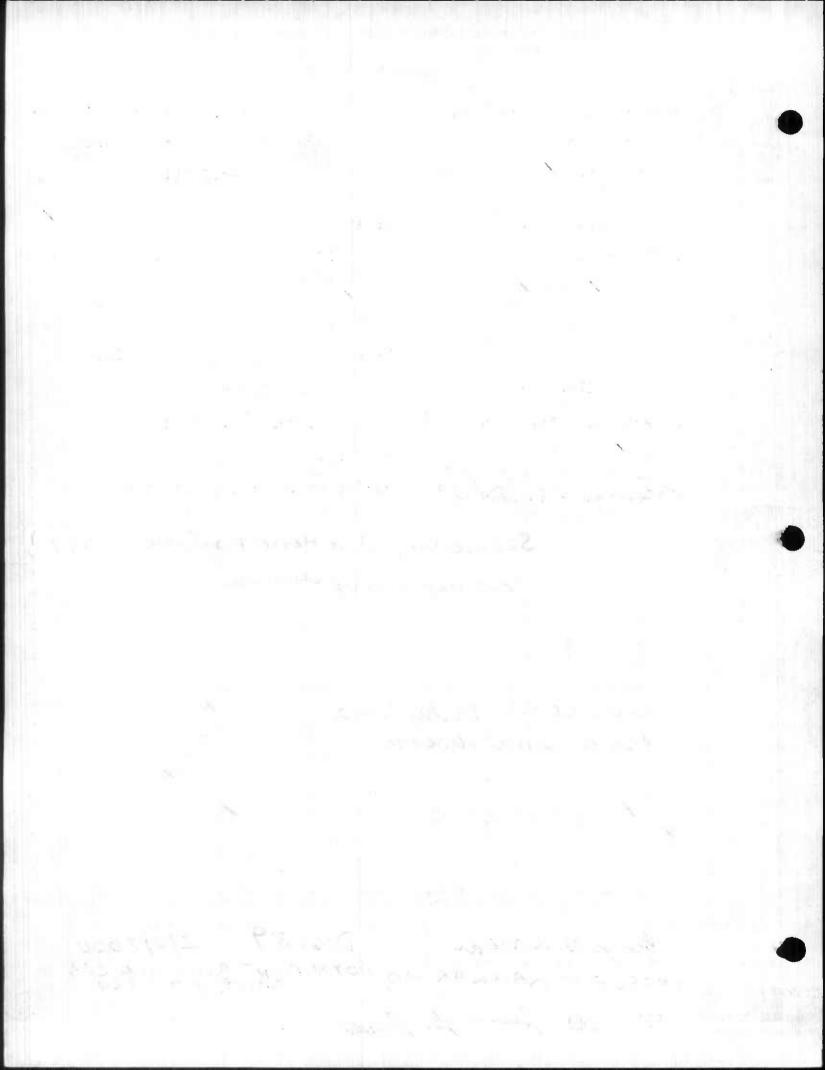
DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** William Wayne McLaughlin 4e. Fecility Neme (If not institution, give street end number) 7:05P.M. 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1730 Rita Rd. Dundalk Baltimore If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. Director 162-14-5324 Dec. 2, 1918 PA Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Baltimore Dundalk 10e. Street end Number 10g. Citizen of Whet Country? 1730 Rita Rd. U.S.A. Funeral 21222 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Rece - American Indian, Bieck, White, etc. 11. Maritel Status filed within 72 hours after 1 Never Merried 2 Merried 1□Yes 2ØNo Specify: WW II 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Eiementery/Secondery (0-12) Coilege (1-4or 5+) 12 Welder Steel Co. Saltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surneme) . Pages 1 and 2 should be fill ment of Health end Mentel Hiant: If item 27 is marked oth Be traumatic Raymond McLaughlin Mary Stark 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health or important: if item 27 is any injury or other trau 1730 Rita Rd. Dundalk, MD 21222 Alberta M. McLaughlin 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removei from State Baltimore-Wash.Crem. 2 - 54 ☐ Donetion 5 ☐ Other (Specify) Laurel, 21. Signature of Funeral Service Lie 22. Neme end Address of Fecility Bradley-Ashton-Matthews Funeral Home 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate **Physician** Severe Congestive Heart Failure Immediate Cause (Final disease or condition resulting in deeth) Examiner Coronary artery disease The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach Severe COPD, arrhythmia Chronic renal disease 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate f or Attanding Physician: after death. Director: After this certifica Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stefe) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D16189 Leonge N. Karkan 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 1107 N. POINT BLVD suit 223 (LEDRI. E. N. KARIKAR MO, 1107 N. BALTO MD 31224 JEDRUE N, KARILAR MO 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MITCHELL EVELYN FEBRUARY 10 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GREATER BAI
5. Social Security Number BALTIMORE MEDICAL CENTER

Number | 6. Sex | 7. Age (In yrs. last birthday) BALTIMORE H Under 24 Hrs If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Funeral Days -30-8085 1□M 20(F Hours 13 1-1-192 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ahon LATONSUI ILE BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Nerns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heelth and Mentel Hygiana. Important: If Itam 27 is marked other than "natural". or Many Injury or other traumatic averages. 1 Never Married 2 Married 1□Yes 2NNo Specify Specify: WHITE é 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
| life. DO NOT use retired) 16b. Kind of Business/Industry
JOHNS HOPLICS 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administration

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 218 No

01:15 A.M.

Year

18. Mother's Name (First, Middle, Maiden Sumame)-

Date

2-11-00

WITZHE FUNERAL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MATTHEWS

20c. Location - City or Town, State

281. Location (Street and Number or Rural Route Number, City or Town, State)

CEBKUAKY

MARRAND

29d. Date signed (Month, Day, Year)

21204

2000

aurel, MD

Home, Inc

21228

Approximate Interval Between Onset and Death

DAY

MD

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital or Attending Physician:

this

After

death.

To the Hosp within 24 hos To the Fune completely fi

Certification: To Be ie Hoepital or Attendi in 24 hours after death ie Funeral Director; / pletaly filled in by tha f

480

Examiner

Be

Physician/Medical by Completed

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

FRED

29b. Signature and title of certifier

31. Date filed (Month Pay Year)

17. Father's Name (First, Middle, Last)

NYNOWN

1 Burial 2 Cremation

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

6 Could not be determined

CHAN

CHANI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

3 Removal from State

BIEN

4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed

physician and the burial-transit

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): TACHYCARDIA VENTRICULAR MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) DEGOXING 0 4 Y TOXICITY Due to (or as a consequence of) SEPSIS OAY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 22 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Z Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident

20b. Place of Disposition (Name of cemetery, crematory or other place)

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MYOCARD IAL

22. Name and Address of Facility

INFARCTION

State Registrar

DHMH 16 Rev 6/95

M. 0

6701

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

N. CHARLES STREET

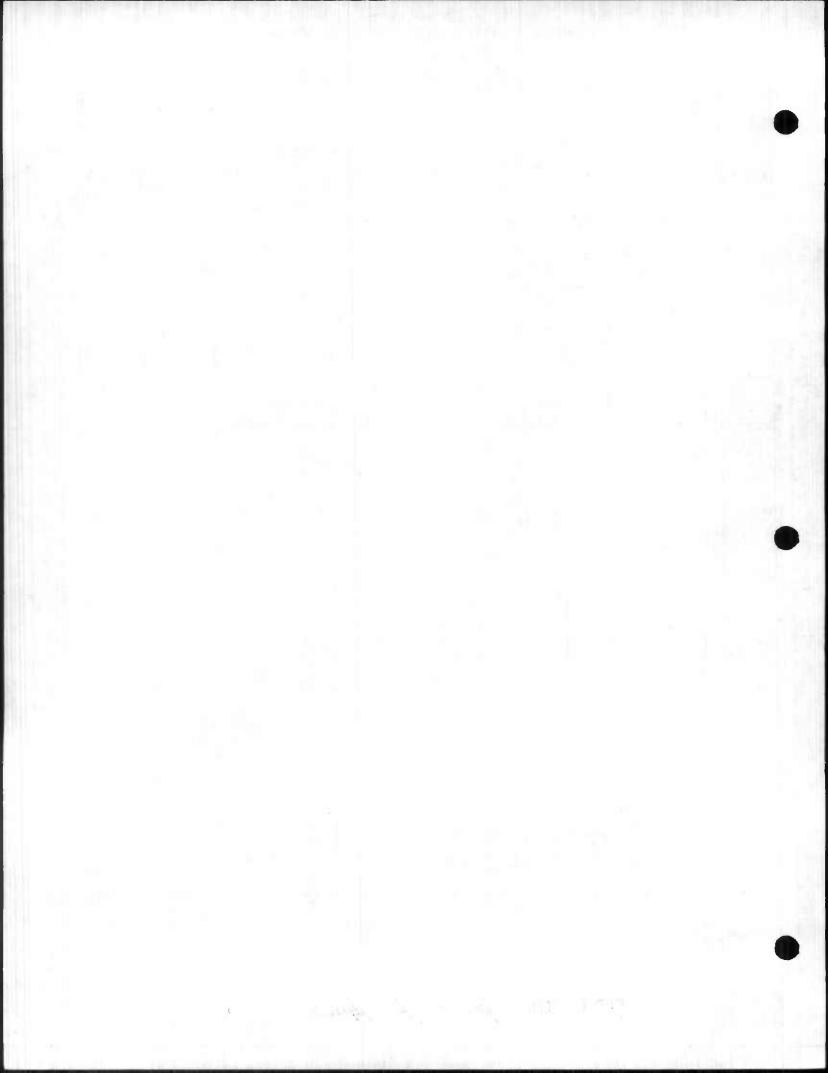
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

053430

BALTZMORE



Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible.

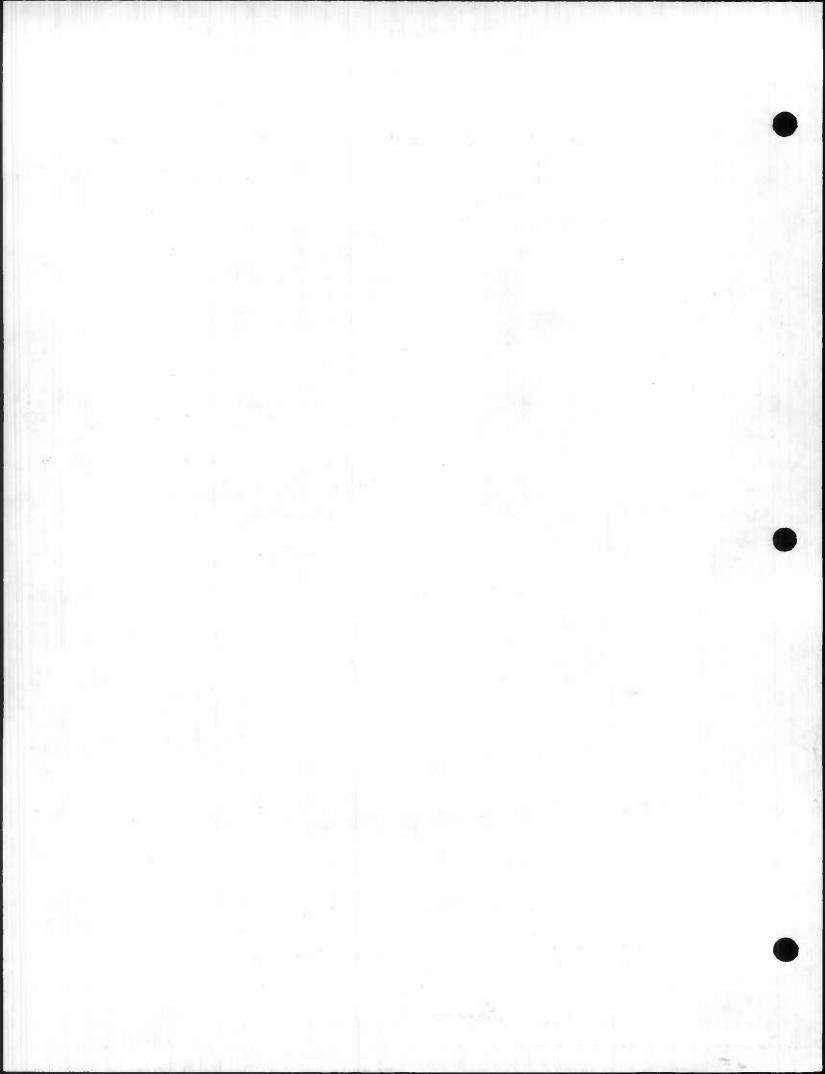
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 07, 2000 2:00 PM MARIE E. OTT /Medical 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CHARLESTOWN ERICSON RETIREMENT COMMUNITIES BALTIMORE 7. Age (In yrs. last birthdey) 77 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2X F Director 219-18-1324 NOV. 8, 1922 MARYLAND Usuel Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits show r 28a-f show notified at 1 Yes 2 No Director BALTIMORE MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 715 MAIDEN CHOICE LANE UNITED STATES Berns 23a 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Giva 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: à 3€ Widowed 4 Divorced Year or Detas: Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17, Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hants (of Health and Mental Hants II is marked off jury or other traumatic even Be WILLIAM NEUNER MARY GOELLER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 808 S. BEECHFIELD AVENUE, BALTIMORE, MARYLAND 21229 DALLAS ARTHUR-NEPHEW 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 02-10-00 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 21. Signeture of Fune al Service License 22. Name end Address of Facility
LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediete Cause (Finel Cardiavascu disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) Examiner extension ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medicai the Due to (or as a consequence of) 88 USB I signed by the a P.O. Part It. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24a. Wes an autopsy performed? 24b. Ware eutopsy tindings available prior to completion of cause of death? page 2 has 1 Yes 2 NO 1 Yas 2 No certificate Division of Vital or Attending Physician: director 25. Wes case referred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifie Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end menner steted. within 2 To the 29b. Signeture and title of certifier 29c. License numbe 29d. Dete signed (Month, Dev. Year) Cettri M.D. 100 D 0009601 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) Randallstown obbins, MD: 5400 Solomen Old Court

Registrar **DHMH 16 Rev 6/95**

State

31. Dete tiled (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a,26 perPhyG780 2/11/2000 EW 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** UEWILLIE 6:00 PM JAN 5,2000 4c. County of Death /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not Institution, giva street and number) Examiner 2530 FIRMA ROAD BALTIMORE TERRA If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) ff Undar 1 Yaer 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 1□M 281F Months Days MARCH 04, 1899 GEORGIA 215-18-1879 00 Yrs. Usual Rasidence of Decedant 10a, Sfeta 10b. County 10c. City, Town or Location 10d. Inside City Limits Vas 2□No Director MARYLAND 10g. Citizen of What Country? 10e. Sfreef and Number USA. TERRA FIRMA ROAD 1225 Funeral 14. Rece - Amarican Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedanf of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marifel Stefua 1 ☐ Yas 2 🕱 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No þ BLACK 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Cotlege (1-4or 5+) to MEMAKER OWN 6THGRADE HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) 88 JAMES HANDY (MN-UNKNOWN) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2530 TERRA FIRMA RD. BALTIHORE, MO. 21225 20c. Location - City or fown, State ARIE OWENS DAUGHTER 20b. Plece of Disposition (Nama of cematery, crematory or other place) 20e. Mathod of Disposition Data 1⊠ Buriel 2 □ Crametion 3 □ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) KING MEMORIAL PARKOI-11-00 WOODLAWN, MARYLAND H. BROWN JR. FUNERAL HOME FULTON AVE., BALTO. MD. 2121 21. Signal une of Funaral Service\Lices 22. Nama and Addrass of Facility JOSEPH 2140 N. vams MD. 21217 23a. Parif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRTHYMIA Immediata Causa (Final disaasa or condition resulting in death) Dua to (or as a consequence ot) Physician/Medical Examine Sequantially tist conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequenca ot): Dua to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 20 No 3 Probably 4 Unknown 1 Yss Completed by 24b. Were autopsy findings 24a. Was an autopsy available prior to complation of causa of death? 208 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicat axaminar? 89 26. Placa of Daath (Check only one) 20 No Hospital: Other: 4 🖾 Nursing Home 2 1 Yes 1 inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance ome 5 Rasidance 6 bother (28d. Dascribe how injury occurred 28a. Data of tnjury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima of tnjury at Work? 5 Panding Invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could nof be determined

attending physician Box 68760 Dried by Miles Division of Vital Records. The law page 2 certificate has Physician: After this al or Attending P after death. I Director: After I

Funeral

Director

28a-f show

8

"natural", or items 23s.

than

Ith and Mental Hygio 27 is marked other r traumatic event, ti

Ceparum I. Pages 1 and 2 should be file
Ceparum and Mental Hy
Ceparumant: if item 27 is marked other
any injury or other traumatic event,
other

Physician

/Medicat Examiner

filed within 72 hours after

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

4 T Homicida

28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and mannar stated. 29b. Signature and title of pertifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

30. Name and addrass of person who complated causa of deeth (Item 23a) (Type, Print)

312 ~17 Nu C 31. Data filad (Month, Day Yaar)

32. Registrar's Signatura

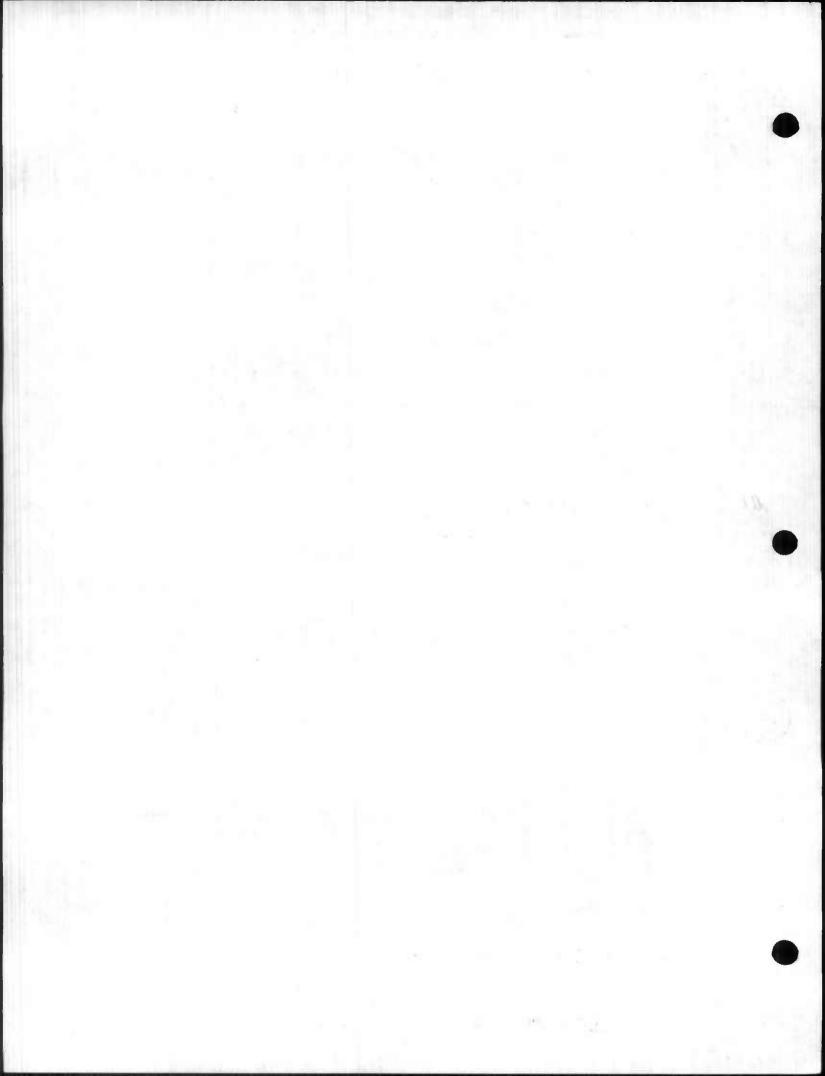
DHMH 16 Rev 6/95

within 24 hours a To the Funeral C To the Hospital

edical

State Registrar

29a. Certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Richard W. Oldewurtel 9, February 2000 4:10 p.m. 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Nursing Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 64 213-32-1348 Mar. 28, 1935 Baltimore, Md. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 X Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3405 Orlando Avenue 21234 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Processor State of Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward W. Oldewurtel Hilda Krug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marcella A. Oldewurtel (Wife) 3405 Orlando Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State 2/14/00 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Ucansee Milton J. Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that quised the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final envs diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 (Other (Specify) 40 Spice 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

the page 2 s

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

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Pages 1 and 2 should be sent of Health and Mental Department of Health and Menta important: If Nem 27 is marked i any injury or other traumatic ev

Physician /Medical

Examiner

P.O. Box 68760

Records,

Division of Vital

Sidewurte

3/6/00

Director

Funeral

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Physician/Medicai λq Completed Be

3 Suicide

29a. Certifier (Check only one)

4 T Homicide

Medical Certification: To this filled in by

or Attending Physician: 24 hours after death. Funeral Director: A Hospital within 2 \$

State Registrar

29b. Signeture and title of partifier

6 Could not be determined

und

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

† Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

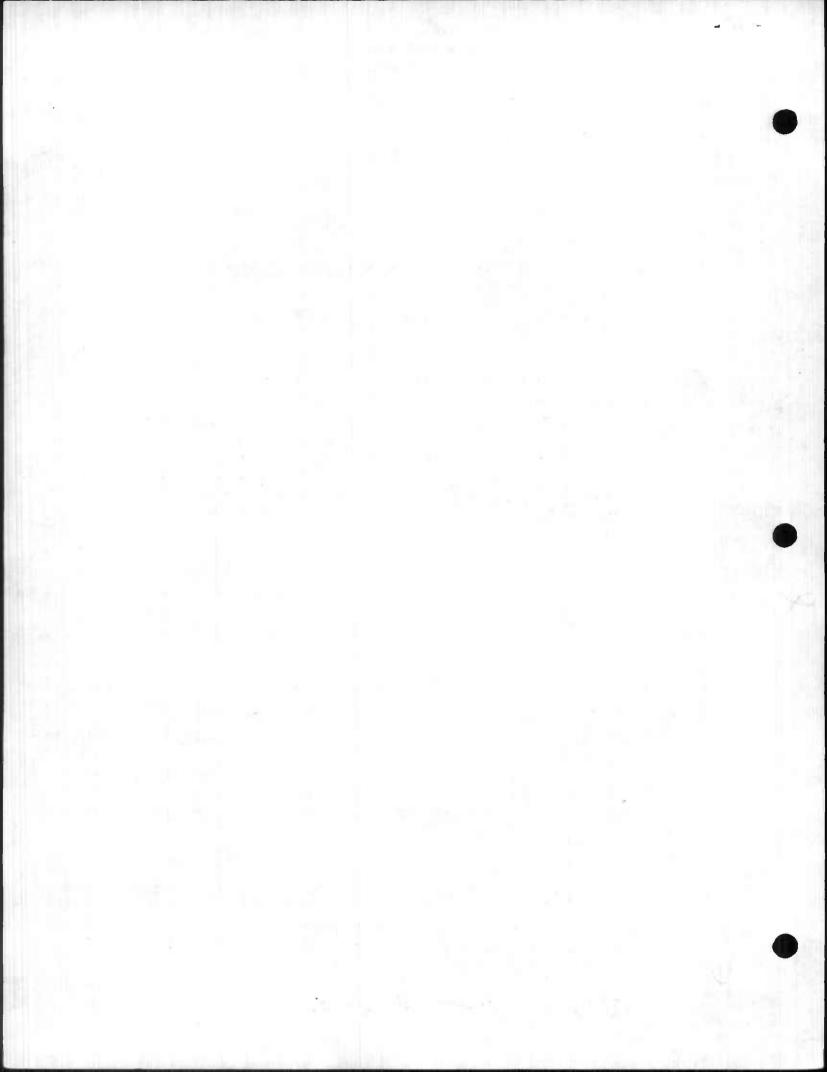
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deal (Litern 23a) (Type, Print)

6701

32. Registrer's Signature 22mer

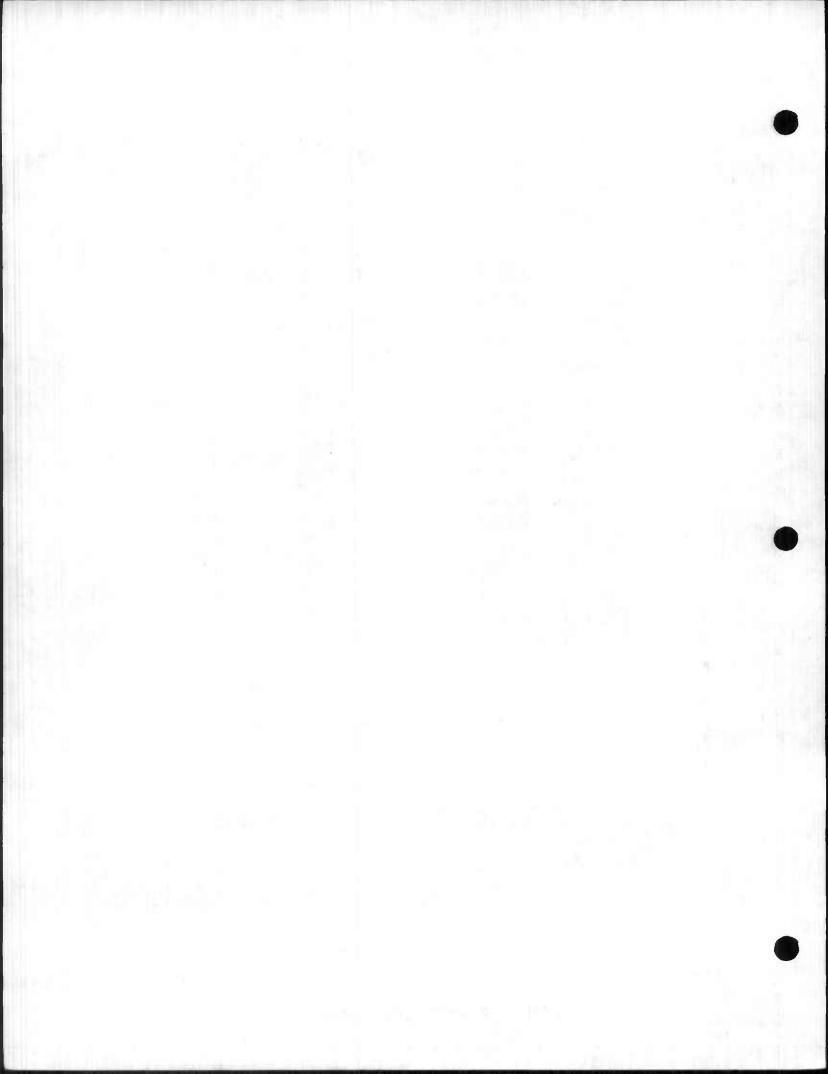
N. Charles St. Bolto. and 21204



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State of Maryland / Department of Health and Mental Hygiene 00 04267

| | | , | Cer | tificate of | Death | | Reg. No. | 1 04661 | | | |
|---|---|---|------------------------------------|---|---|--|--------------------------------------|--|--|--|--|
| | 1. Decedent'a Name (First, Middle, Last, | | | | *************************************** | 2. Date of D Month | | 3. Time of Death | | | |
| Physician /Medical | ELEANORA V. PETER | SON | | | | Februa | | | | | |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town, | or Location of Dea | th 4c. County | | | | |
| E L | Mariner Health of | Forest Hill | | | Forest | | Harfo | ord | | | |
| Funeral Director | 213-14-3840 | 7. Age (In yrs | . last birthday) Yrs. | If Under 1 Year Months Days | | Vin (Month, D | orth ay, Year) 0, 1914 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Pu Bu | Usual Residence of Decedent 10a, State 10b, County | 10c, C | ity, Town or Lo | cation | | | | 10d. Inside City Limits | | | |
| Se-f sho | Maryland Harford | | el Air | | | | 1 N Yes 2 No | | | | |
| of the control of the Market Control of the Market Control of the Con | 10e. Street and Number 300 Sunflower Dri | ve | | 10f. Zip Code 21014 | | | U.S.A. | | | | |
| Dy | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | Vas Decedent of I Yes, specify Cut I□ Yes 2⊠ No | | ? (Specify Yes or Nuerto Rican, etc.) | o- 14. Race Blace Specify | e - American Indian, sk, White, etc. White | | | |
| od within 72 ho ygiene. For then "neturing, the Medical Completed | 15. Decedent's Edu (Specify only highest grad | | 16a. Deced | lent's Usual Occu | pation | working | 16b. Kind of Bu | usiness/Industry | | | |
| 21 Paritin | Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | OO NOT use retire | ed) | working | | | | | |
| M BEST O | 8th grade | | Nurs. | ing Comp | | | | th Care Agency | | | |
| Maryland d2 should be file h end Mental Hy reumatic event To Be | 17. Father's Name (First, Middle, Last) | | | | | Name (First, Middle | | 18) | | | |
| should ind Men marke | Sylvester Cholewc | zynski | | | Valer | ie Hepner | L | | | | |
| Aar and le m | 19a. Informant's Name/Relationship (Ty | | | | | r Rural Route Num | | | | | |
| re, N f Heaith frem 27 other tr | Constance Francis | | | | ns Plac | e, Bel A | 1 | | | | |
| A 0 0 | 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆 R | | Place of Dispo- cemetery, cren | sition (Name of natory or other pla | ice) | Date | 20c. Location - | City or Town, State | | | |
| altimor | 4 Donation 5 Other (Specify) | Sa | t. Stan | islaus C | emetery | 2/11/00 | Dundal | 2k, Maryland | | | |
| Baltimore permit. Pages 1- Department of He important: if hem any injury or oth- ance. | 21. Signature of Funeral Service License | ulen | S 6 | Name and Addr Chimunek 10 W. Ma | ess of Facility Funera CPhail | l Home of Road, Be | Bel Air. N | r, Inc. MD 21014 | | | |
| | 23a. Part1. Enter the disease, or compli shock, or heart laiture. List only or | cations that caused the dea | | | | | | Approximate Interval Between | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | pul | or as a conseq | aug h | yperte | Tursen); | phon | Onset and Death | | | |
| i i | | Due to (| or as a conseq | uence on | , | | | | | | |
| 68760, Hilloate be assecuted as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events | Due to (| e to (or as a consequence of): | | | | | | | | |
| 0 = 0 = 2 | resulting in death) Last | | or as a conseq | uence of): | | | | | | | |
| destricent | | | | | | | | | | | |
| A die | Part II. Other significant conditions con | tributing to death but not re- | sulting In the ur | nderlying cause g | iven in Part I. | 23b. Dic | l tobacco une co | ntribute to the cause of death? | | | |
| Ph detac | recent un | way Trac | 1 in | Lestro | ~ | 10 | Yes 2QNo | 3 Probably 4 Unknown | | | |
| requir requir should | | 9 | | | | | s an autopsy omed? | 24b. Were autopsy lindings available prior to completion of cause of death? | | | |
| | | | | | | 1 🗆 | Yes 2 No | 1□ Yes 2No | | | |
| Vital F alcien: The cartificate irector, pag o Be Co | 25. Was case referred to medical | | | | 26. Place of | Death (Check only | one) | | | | |
| | axaminer? 1 ☐ Yes 2 ☐ No | lospitat: | ER/Outpatien | t 3□ DOA O | hor. | ng Home 5 Res | | er (Specify) | | | |
| Vision of Attending Phyr ordeath. ector: After this by the funeral of | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | - | how injury occur | | | | | |
| 2 9492 | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | (Street and Numb own, State) | per or Rural Route Number, | | | |
| To the Hospital within 24 hours | 29a. Certifier (Check only one) Certifying Physical Examination (Check only one) | ician: To the best of my kneer: On the basis of examinated manner stated. | owledge, death ation and/or inv | occurred at the trestigation, in my | ime, date end p opinion, death o | lace, and due to the occurred at the time | cause(s) and ma , date and place, | inner as stated. and due to the cause(s) | | | |
| THE PERSON | 29b. Signature and title of certifier | | | 29c. Licen | se number | | 29d. Dele signe | d (Month, Day, Year) | | | |
| | Dew 15 | Sum | | D | D32299 February 9,2000 | | | | | | |
| 11/01 | 30. Name and address of person who co | mpleted cause of death (Ite | | | | | | | | | |
| /W | DAVIDS BUNK | | | MacPhai | l Road, | Bel Ai | L, MD 21 | 014 | | | |
| State Registrar | 31. Date filed (Month, Day, Year) FEB 1 1 2 | 32. Registrar's Sign | atura & | . Ana | Wal. | | | | | | |

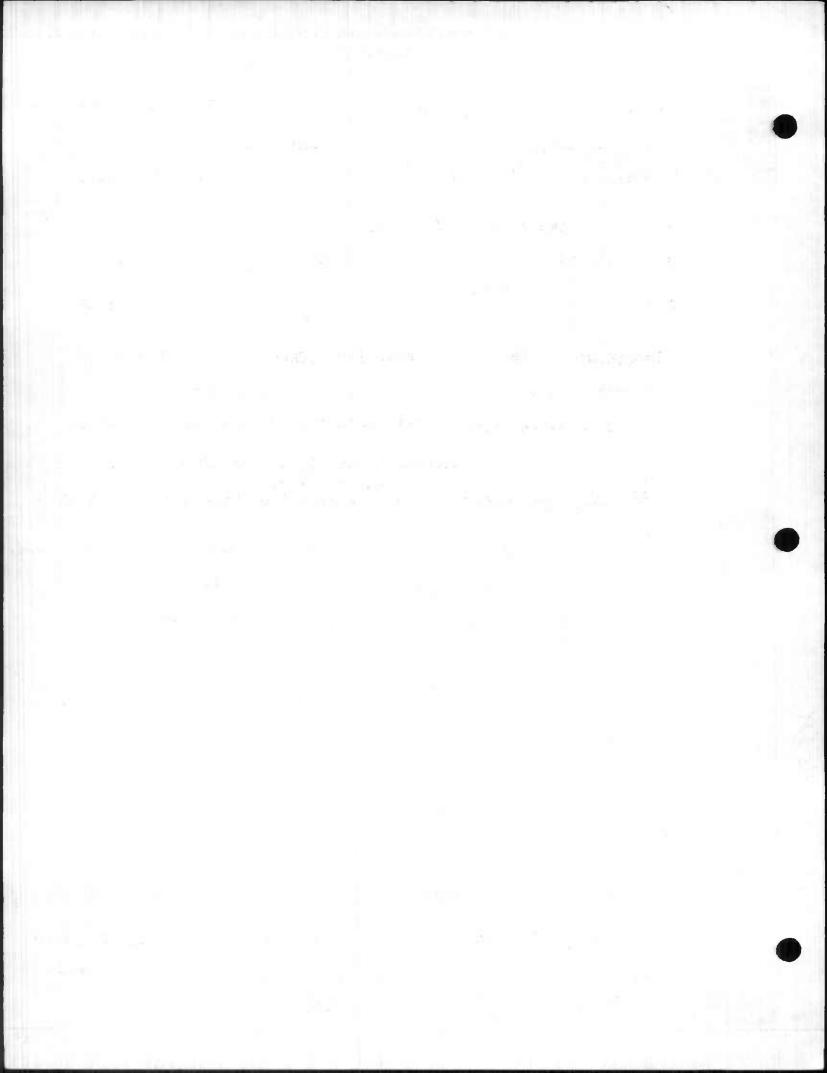


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** FEBRUARYO7, 2000 Year 0145 A.M. Virgie /Medical M. Porter 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Neme (If not Institution, give street and number) Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) St. Agnes Hospital 6. Sex 1 □ M 2 ☑ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Yrs. Director 242-54-3514 Usual Residence of Decedent 94 11 03 05 N.C. the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits rthan "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Catonsville Director Baltimore Co MD 10e. Street and Numbe 10g. Citizen of What Country? filed within 72 hours after death with Funeral 1026 Kent Ave 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 Yes WNo 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: ò %Widowed 4 □ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 3rd grade Domestic Worker Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be file ment of Health and Mental Hi ant: If item 27 Is marked oth King Arthur Porter Fannie Parker 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Kent Ave, Catonsville, Md Lottie Demory-Daughter 20e. Method of Disposition 21228 20b. Placa of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurlal 2 Cremetion 3 Removal from State = 8 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 2/12/2000 Arbutus, Md
22. Name end Address of Fecility
March F/H West 21. Signature of Funeral Service Licansee S 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset end Death **Physician** a ACUTE MYOCAZDIAL /Medical tmmediate Cause (Finel 30 MINUTE INFARCTION disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner FAILURE CONGESTIVE HEART Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last Due to (or aa a consequence of): CURUNARY ARTERY physician Physician/Medical g. Due to (or es e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to Completed 24e. Was en autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury at Work? 5 Pending 1 Natural Hospital or Attending 24 hours after death. Funeral Director: Alt 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Ho within 24 h To the Fur 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Clubs lute MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES CURTIS 57 AGNES MOSPITAL

State Registrar 31. Date filed (Morth East Yar) 2000

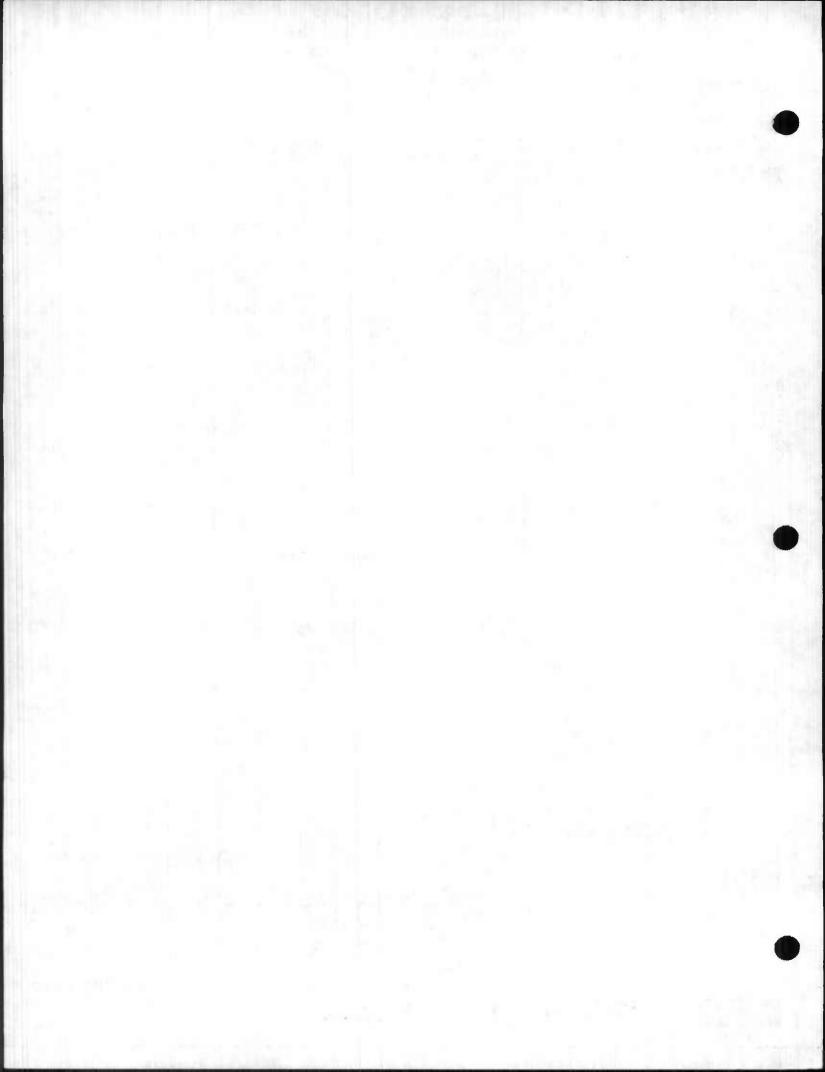
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| | . Decedent's Nema (First, Middla, Las | 1) | | Certifica | | | 2. Data of D | | | 3. Tim | a of Deeth | | |
|---|--|---|-----------------|---|---------------------|----------------------|---|--|------------------------|----------------------|---------------|--|--|
| ın | JOHN | | | PER | KO | V | Month FEBRU | Day | Yeer Zoou | . 15 | 55pm | | |
| 1 | a Facility Name (If not institution, give | street and number) | 4 i | , | | lb. City, Town, or I | | | unty of Deet | | Pi | | |
| ľ | 77 11 | HOPKING | 110 | 50'ta | | DIL | more | | n/a | | | | |
| 4 | heJohns Social Security Number 6. So | | yrs. last birth | dev) If Und | ar 1 Yeer | if Undar 24 Hrs. | | | | holace (Ste | ta or Foreig | | |
| 1 | | M 2DF | | rs. Months | | Hours Min. | (Month, D | | | | nta or Foreig | | |
| 1 | Jsuel Residence of Decedent | | 32 | | | | Januar | y 13,1 | 940 P | iaryla | and | | |
| 1 | 0a. State 10b. County | 10 | c. City, Town | or Location | | | | | | 10d. Inside | a City Limits | | |
| i | Maryland Baltimo | | Baltim | 0.24.0 | | | | | | 101 | res 2 No | | |
| € ⊢ | Oe. Street and Number | re . | Dailli | | ip Code | | | 10g. Citizen | of Whet Co | untry? | | | |
| | 2022 W11 A | | | | 11007 | | | ** * | . 1 0. | | | | |
| | 2932 Maryland Ave | nue 12. Wes Decedent Ever | in U.S. | | 21227 edent of H | ispanic Origin? (S | pecify Yes or N | | ted St | | ٦, | | |
| | 1 Never Merried 2♥ Married | Armed Forces? | | ff Yes, sp | ecify Cuba | ın, Mexicen, Puart | o Rican, etc.) | | Black, White | e, etc. | | | |
| | 3 ☐ Widowed 4 ☐ Divorced | 1 ☑ Yas 2 ☐ No If Yes, Give 19 Year or Detes: | 65-69 | 1 🗆 Yes | 2 No | Specify: | | Spe | ecity: Wh | ite | | | |
| - | 15. Decedent's Ed | | 160 [| Decedent's Us | uel Occup | ation | | 16b. Kind o | of Business/ | Industry | | | |
| - | (Specify only highest gree | de completed) | | Give kind of w life. DO NOT | ork done | during most of wor | rking | | | , | | | |
| | Elementery/Secondery (0-12) | College (1-4or 5+) | mechanic | | | | | | dieta | listribution | | | |
| | 7. Fathar's Neme (First, Middle, Last) | 0 | me | CHanic | | 18. Mother's Ner | ne (First, Middle | | | . IDuc. | LOII | | |
| | Allon Donlars | | | | | Erro 1 vrn | Bender | | | | | | |
| - | Allen Perkov 19a. Informent's Neme/Reletionship (7) | ima Printi | 10h | Mailing Addra | ee (Street | end Number or Ru | | her City or To | um State 2 | Fin Code) | _ | | |
| | | | | | | | | | | | | | |
| - | Cathy L. Perkov - | | | 32 Mary Disposition (N | | Avenue, | Dete | 7 | D 212 ion - City or | | | | |
| 1 | 1 St Burial 2 ☐ Cremation 3 ☐ | | cemetery | , crametory or | other pled | (e) | 5010 | 200. 2004 | on ony or | TOWN, Oldi | 1 | | |
| | 4 ☐ Donation 5 ☐ Other (Specify |) | Lake V | | | 1 Park | | | | | | | |
| 1 | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue | | | | | | | | | | | | |
| | unn y | enue land | | | | | | | | | | | |
| 1 | 23a. Part1. Enter tha disease, or shock, or heert failure. List | | 10110 | Approxi | | | | | | | | | |
| | Shock, or heart failure. List only t | AND CAUSE ON BACK INTO. | | | | | | | 3 | Onset a | nd Death | | |
| Immediate Cause (Final disease or condition CEREBRAL HERWINTION | | | | | | | | | | 33 | min | | |
| | resulting in death) | a | | onsequence of | | 7711074 | | | | 00 | (1041) | | |
| | | | EX EX | | | Paxin | | | | 30 | \ | | |
| | Sequentially list conditions | b | | onsequence of | | | | | | -0 | D.C. | | |
| | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying | | PTURO | | | 50001 | AWEU | KYSM | | 30 | , | | |
| | cause (Disease or Injury that initieted events | C | | ARED CEREBRAL AWE | | | | | | 20 | hr | | |
| 5 | resulting in death) Last | | | | | | | | | | | | |
| riiyaiciai vm | | d | | | | | | | | | | | |
| | 2nd II. Other eignificant conditions of | ontributing to death but not resulting in the underlying cause given in Pert I. | | | | | 23b. Dfd tobacco use contribute to the cause of | | | | see of dee | | |
| | with other eignineant conditions of | and during to death out no | A resulting III | ara arraerrying | couse Alv | OI WIT OILE. | | 3b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4 | | | | | |
| | Hypertensi | 0- | | | | | ,, | , 100 & | | Juling | X-min | | |
| | / . | | | | | | | s en autopsy | 24b. | Were autor | sy finding | | |
| Paraldina | | | | | | | per | formed? | | available processing | | | |
| | | | | | | | | | | of death? | and . | | |
| | | | | | | | | Yes 2 Qh | 10 | 1 🗆 Yas | 2)K) No | | |
| | 25. Was case referred to medical axaminer? | Hospital:/. | | | Oth | 26. Place of De | | | | | | | |
| | 1 Yes 2 No 27. Manner of Death | 1 M Inpatient | 2 ER/Out | | JOA | 4 U Nursing F | lome 5 ☐ Re | | | cify) | | | |
| 1 | 1 Netural 5 ☐ Pending | (Month, Dey Year) Injury Work? M 1 Yes 2 No | | | | | | 28d. Describe how injury occurred | | | | | |
| | 2 Accident investigation 3 Suicide 6 Could not be | | | | | | | | | | | | |
| | 4 ☐ Homicide determined | building, etc. (S | | 28f. Location (Street end Number or Rurel Route Number, City or Town, State) | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| | (Check only 2 Medical Exam | sician: To the best of my | | | | | | | | | se(s) | | |
| | one) | and manner stated. | | | 9c. Licans | | | | | | | | |
| 1 | 29b. Signature and title of certifier | 29d. Date signed (Month, Dey, Year) | | | | | | | | | | | |
| | monumb mo mo Dalo Februar | | | | | | | | | > 20 | 000 | | |
| _ | 0. Name and address of person who o | ompleted cause of death | (Item 23a) (1 | Type, Print) | | | | | | | | | |
| 1 3 | | | , , | | | | | | | | | | |
| 3 | Morex MITSE | I ma J | ohns F | topkin! | , 6 | 00 N. W. | offe St | Baltu | mers ! | S QM | 128 | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month PUSh Howard February 09 2000 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BON SECOURS HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer)
March 25 1923 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) Months Deys 15 M 2□ F 215-12-5984 Yrs. 76 Maryland Usuei Residence of Dacedent 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severn 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 7959 Telegraph Road 21144 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Biack, White, etc. 11. Meritel Status 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Eiementary/Sacondery (0-12) Coilege (1-4or 5+) Poplar Club Driver 10th 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ollig Otis Pugh Grace Betz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road Terry Pugh / son Severn Md. 21144 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Cemetery 2/11/2000 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
Connelly Funeral Home of Essex 21. Signeture of Funerel Servica Licansee 300 Mace Ave. Baltimore Md. 21221 Enter the disaese, or omplications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heer feilure. List phy one ceuse on eech line. Approximate Interval Between Onset and Deeth Immediate Cause (Final Aspiration pheninonia diseese or condition resulting in deeth) Due to (or as a consequanca of):

Physician /Medical Examiner

physician a s the burial-1

signed by the a

need page 2 s

certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Physician

Examiner

Funerai

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examinar must be notified at

the Maryland

72 hours after

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If I lem Z7 Is marked other than any Injury or other traumatic.

Baltimore, Maryland 21215-0020

/Medical

Director

Funerai

p

Completed

Examiner Sequentielly list conditions, If eny, leeding to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in deeth) Lest

Respiratory

Due to (or es e consaquence of):

Sephiemia

Due to (or es e consequence of):

Sacrel Wicer infected

29d. Date signed (Month, Dey, Year)

Physician/Medical Pert II. Other significant conditions contributing to deeth but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Hepstins þ 24b. Ware eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy performed? LANNAICE Renal Falling. 1 Yes 2 X No 1 ☐ Yes 2 No 25. Was case refarred to medical exeminer? 26. Piace of Deeth (Check only ona) Hospitel: 1 npatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Mannar of Deeth 28a. Data of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury et Work? 1 Naturai 2 Accidant 5 Pending invastigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicida edical 29a, Cartifian Cartifying Physician: To the bast of my knowledge, daath occurred at the time, dete end place, end dua to the causa(s) and menner as steled.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurred at the time, data end place, and dua to the cause(s) and mennar stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; g

hiokpeha, mo 31. Dete filed (Month, Day, Year) State 11

29b. Signature end title of certifier

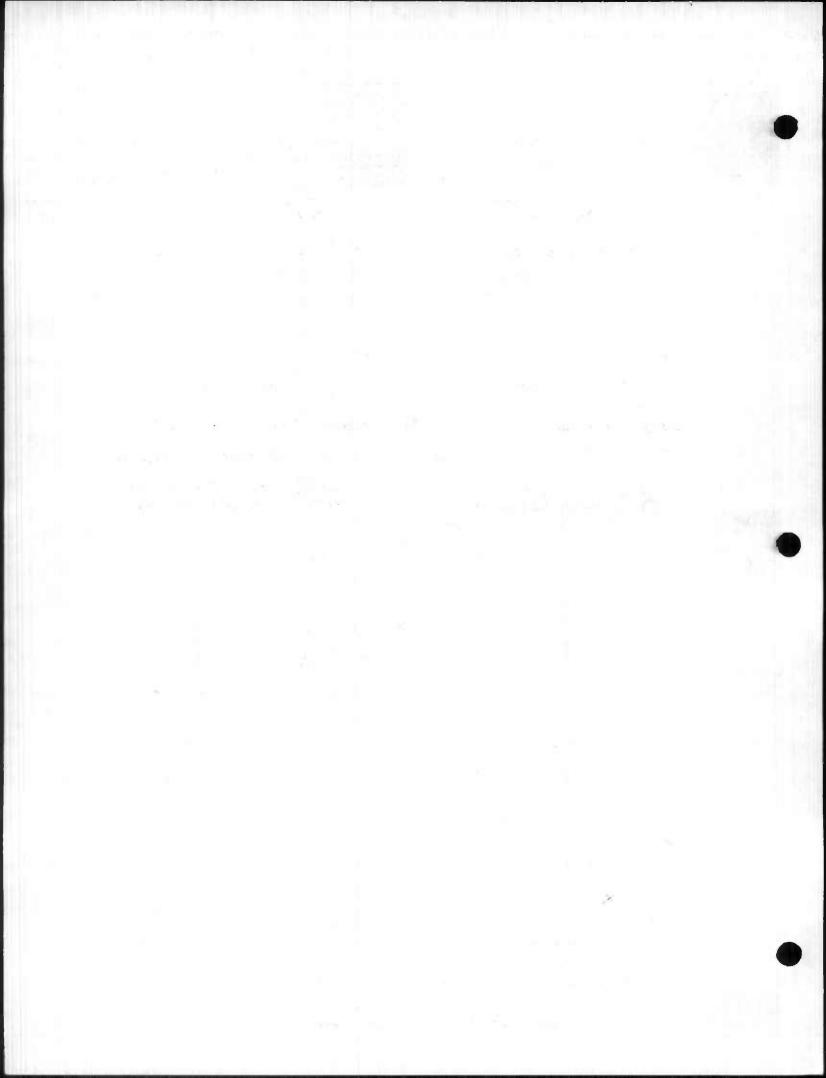
2600 Liberty HCGS AVE Balti MD 21215 32. Registrer's Signatura

30. Name end eddrass of parson who complated causa of daath (itam 23a) (Type, Print)

29c. License number

30115

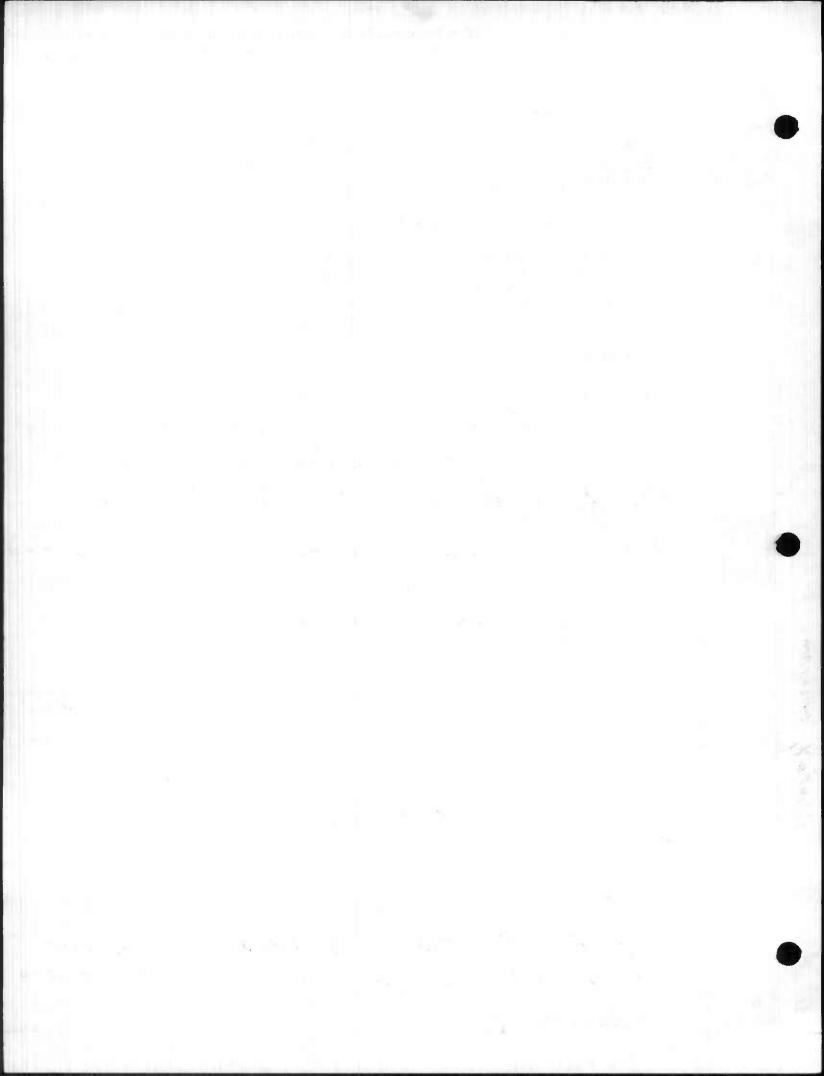
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 9 FEBRUARY 2000 1232 WILLIAM POMPEY /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL NIA BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10 M 2□ F Days 215-40-6382 Yrs. MD Director 03-06-Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MO NIA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 AUENUE 23a 1815 ARUNAH 21217 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 "natural", or 1 Yes 2 No p 3 ☐ Widowed 4 ☑ Divorced BLACK Completed h end Mental Hygiene.
7 is marked other than "natur traumatic event, the Mag call 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) YRS 12 TH GRADE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumame) 2 should be fi end Mental H **MOMPEY** WALLACE JACKSON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health en-ant: If Item 27 is r ury or other traus WALLACE BALTO + ATHER mo 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Separtment LOUDON PARK CEMETERY 2.15.00 BALTO. MD 4 ☐ Donation 5 ☐ Other (Spacity) 22. Name end Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Servica Licensee 5151 BALTU. NATL PIKE, BALTU. MO. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximete Interval Between Onset and Dealh **Physician** /Medical Immediate Cause (Final CARDIAC ARRHY THOMIA 30 minus disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner HYPER TENSION icien and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulling In death) Last Due to (or as a consequence of): RENAL FMLURE Box 68760, physicien the burie (MRONIC Due to (or as a consequence of): use signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably .4 Unknown þ 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? PUMPEY page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury el Work? After Division 5 Pending investigation 1. Naturat 1 Tes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 4 Homicide tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) end mannar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) D0051865 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) BATAMORGIND CUMAS mD oaks 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State Registrar **DHMH 16 Ray 6/95**



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | | 0.0000 | 0. | Death | | Reg. No. | | | |
|--|---|--|--|--|---|---|--|--|---|--|--|---|---|---|--|
| Physicia | | 1. Decedent's Neme (First, Middle, Last) | | | | | | | 2. Date of De Month | eath Dey | Year | 3. Tima of Death | | | |
| /Medica | al | bruce A. Frothero | | | | | | | FEBRUA | - | 000° | 1201 PM | | | |
| Examine | er | 4a Facility Name (SINAI H | | | | | | | | 4b. City, Town, or I BALTIMOR | | m 4c. Count | 4c. County of Death | | |
| Funeral Director | | 5. Social Security N 216-64-25 | 584 | 6. Sex | XM 2□F | 7. Age (In) | rs. last birtho | Monthe | 1 Year Days | | 8. Dete of Bi (Month, Do NO V | 6,1964 | 9. Birthpl Count | ace (State or Foreig | |
| 1 | 1 | Usual Residence o | 10b. County | , | | 10c. | City, Town o | or Location | | | | | 10 | Od. Inside City Limits | |
| 28a-f show | ctor | MD Carroll | | | | | Elder | | | | | | | 1 ☐ Yes 2 🕅 No | |
| 23a or 2 | oner than hartres, or fame 238 or ent, the Medical Examinar must be e Completed by Funeral Di | 1692 King Richard Rd. | | | | | 10f. Zip | | 21784 | | 10g. Citizen of | What Count SA | try? | | |
| | | 11. Marital Status 1 Never Man 3 Widowed | | rried | 12. Wes Deci Armed Fo 1 Yes If Yes, Giv Year or D | orces? 2/\lambda No ve | U,S. | 13. Wes Deced If Yes, spec | 10 | Hispanic Origin? (S ban, Mexican, Puert Specify: | pecify Yes or No Rican, etc.) | 0- 14. Ra Ble Speci | ce - America eck, White, e | | |
| han "natur a Madical | | (Spec | 15. Deceden cify only highe ondary (0-12) | | | 1-4or 5+) | (0 | fe. DO NOT us | rk done se retire | during most of wor | king | | | forcement | |
| A O O | | 17. Father's Name | | | ' | | | 1011 | | 18. Mother's Nan | ne (First, Middle Parker | , Maiden Sume | | Silicaro | |
| E E | | 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or | | | | | | | | | | | | | |
| n 27 | Important: If Rem 27 le any Injury or other tre page. | Ann K. F | rother | 0 | Wi | | | | | chard Rd. | , Elder | | | 1784 | |
| 5 = 5 | | | | _ | | | o. Place of D | crematory or o | ther pla | ice) | Date | 20c. Location | - City or To | m, otato | |
| Important: any injury o | | 1 N Burial 2 4 Donation 21. Signature of Fi | 5 Other (S | Specify) | | State | cemetery. | Valley 22. Name en | Mel d Addre | morial Ga ess of Facility eral Home | r. 2/10 11824 | /00 C Reiste | ockey: rstown | sville,MD | |
| ysician Medical aminer | | 4 Donation 21. Signatile of Fo | 5 Other (Surrenal Service the disease, or art failure. List | License r complice t only on | cations that co | State DI | cometery, | Valley 22. Name en Eline enter the mod | Men d Addre Fun e of dyi | morial Galess of Facility eral Home | r. 2/10 11824 Reist | /00 C Reiste erstown | ockeys rstown | sville,MD n Rd | |
| ysician Medical aminer | ical Examiner | 4 Donation 21. Signature of Fig. 1. Signature of Fig. 2. Signature of F | S Other (Suneral Service the disease, or at failure. List (Finel on onditions, namediate entrying injury s | License r complice t only on | cations that co | State DL caused the deech line. Due to | peath. Do not | Valley 22. Name en Eline enter the mod gun sequence of): | Men d Addre Fun e of dyi | morial Ga ess of Facility eral Home | r. 2/10 11824 Reist | /00 C Reiste erstown | ockeys rstown | Sville, MD 1 Rd 21136 Approximete Iniervel Between Onset and Deeth | |
| ykysician and ledical aminer the butel-transit | dica | 4 Donation 21. Signature of Fig. 1. Enter thock, or her disease or condition resulting in death) Sequentially list co if any, leading to incause. Enter Under Cause (Disease or Cause (Disease | S Other (Suneral Service the disease, or at failure. List (Finel on onditions, namediate entrying injury s | License r complice t only on | cations that co | State DL caused the deech line. Due to | peath. Do not | Valley 22. Name en Eline enter the mod | Men d Addre Fun e of dyi | morial Galess of Facility eral Home | r. 2/10 11824 Reist | /00 C Reiste erstown | ockeys rstown | Sville, MD 1 Rd 21136 Approximete Iniervel Between Onset and Deeth | |
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| by the ettending physician and second for use as the burlet-transit | Physician/Medical | 21. Signature of Financial Enter Indick, or head disease or condition resulting in death) Sequentially list co if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) | S □ Other (Superal Services the disease, or in failure. List (Finel on orditions, namediate orlying injury superal services) Last | License complike only on | cations that cause on e | State DL caused the dech line. Due to | peath. Do not of or as a condition of or as a condition of or or as a condition of or as a co | Valley 22. Name on Eline enter the mod gun issequence of): | Men Men d Addre Fun e of dyi | morial Galess of Facility eral Home ing, such es cardiac | r. 2/10 11824 Reist or respiratory of the state of the st | /00 C Reiste erstown | ockeys rstown , MD | Sville, MD n Rd 21136 Approximete Inlervel Between Onset and Deeth | |
| s been signed by the ettending physician and a scholid be deteched for use as the burlel-transit and under the school of the sch | by Physician/Medical | 21. Signature of Financial Enter Indick, or head disease or condition resulting in death) Sequentially list co if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) | S □ Other (Superal Services the disease, or in failure. List (Finel on orditions, namediate orlying injury superal services) Last | License complike only on | cations that cause on e | State DL caused the dech line. Due to | peath. Do not of or as a condition of or as a condition of or or as a condition of or as a co | Valley 22. Name on Eline enter the mod gun issequence of): | Men Men d Addre Fun e of dyi | morial Galess of Facility eral Home ing, such es cardiac | r. 2/10 11824 Reist or respiratory a 0 Und 3 7 e s + | /00 C Reiste erstown arrest. | ockeys rstown , MD ontributa to 3 Prob | Sville, MD Rd 21136 Approximete Inlervel Between Onset and Deeth MINUTE the cause of death | |
| has been signed by the ettending physician and signed by the ettending physician and signed in a signe | Physician/Medical | 21. Signature of Financial Enter Indick, or head disease or condition resulting in death) Sequentially list co if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) | S □ Other (Superal Services the disease, or in failure. List (Finel on orditions, namediate orlying injury superal services) Last | License complike only on | cations that cause on e | State DL caused the dech line. Due to | peath. Do not of or as a condition of or as a condition of or or as a condition of or as a co | Valley 22. Name on Eline enter the mod gun issequence of): | Men Men d Addre Fun e of dyi | morial Galess of Facility eral Home ing, such es cardiac | r. 2/10 11824 Reist or respiratory a 0 Und: 1 = 5 t | /00 C Reiste erstown arrest. tobacco usa c Yea 2 No | ockeys rstown , MD ontribute to 3 Prob | Sville, MD Rd 21136 Approximete Intervel Between Onset and Deeth MINUTE the cause of death eably 4 Unknown re autopsy findings illable prior to inpletion of cause | |
| certificate has been signed by the ettending physician and many properties of the pr | Be Completed by Physician/Medical | 4 Donation 21. Signature of Fig. 1. Signature of Fig. 2. Description of Fig. 2. Descriptio | S Other (Superal Services the disease, or an failure. List (Finel or anditions, namediate entying injury superal services the conditions of the conditions o | License of complications on a confidence on the | cations that cause on e | Due to Due Due to Due | eath. Do not constant to the c | Valley 22. Name on Eline enter the mod gun isequence of): | Mei | morial Galess of Facility eral Home ing, such as cardiac | r. 2/10 11824 Reist or respiratory a 0 Und 3 2 S T | /00 C Reiste erstown arrest. (tobacco usa c Yea 210 No s an autopsy omed? Yes 2 No one) | ockeys rstown , MD ontributa to 3 Prob | The cause of death ably 4 Unknown results prior to make a line of cause death? The cause of death ably 4 Unknown results prior to make a line of cause death? Cyes 2 No | |
| his certificate has been signed by the ettending physician and we provide a director, page 2 should be deteched for use as the burlel-transit and use as the burlel-transit and use as the burlel-transit. | To Be Completed by Physician/Medical | 4 Donation 21. Signature of Fig. 1. Enter the ck, or head disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) Part II. Other significance of the cause (Disease or that initiated event resulting in death) | S Other (Superal Services the disease, or an failure. List (Finel or and the services the servic | License of complications on a confidence on the | cations that cause on e | Due to | eath. Do not of or as a control | Valley 22. Name en Eline enter the mod gun issequence of): esequence of): | Megadadadadadadadadadadadadadadadadadadad | morial Galess of Facility eral Home ing, such as cardiac | r. 2/10 11824 Reist or respiratory a 0 Und 3 2 S T 23b. Did 10 24a. We: perf 189 th (Check only) ome 5 Res | /00 C Reiste erstown arrest. Itobacco usa c Yea 212 No s an autopsy omed? Yes 2 No one) idence 6 00 | ockeys rstown , MD ontributa to 3 Prob | The cause of death ably 4 Unknown results prior to make a line of cause death? The cause of death ably 4 Unknown results prior to make a line of cause death? Cyes 2 No | |
| his certificate has been signed by the ettending physician and we provide a director, page 2 should be deteched for use as the burlel-transit and use as the burlel-transit and use as the burlel-transit. | To Be Completed by Physician/Medical | 4 Donation 21. Signature of Fig. 1. Signature of Fig. 2. Description of Fig. 2. Descriptio | S Other (Superal Services the disease, or an failure. List (Finel or and the services the servic | Complike to the complete to th | cations that ce cause on e | Due to Due Due to Due | eath. Do not constant to the c | Valley 22. Name en Eline enter the mod gun issequence of): esequence of): | Metadadadadadadadadadadadadadadadadadadad | morial Galess of Facility eral Home ing, such as cardiac | r. 2/10 11824 Reist or respiratory a 0 Und 3 2 S T 23b. Did 10 24a. We: perf 189 th (Check only) ome 5 Res | /00 C Reiste erstown arrest. (tobacco usa c Yea 210 No s an autopsy omed? Yes 2 No one) | ockeys rstown , MD ontributa to 3 Prob | The cause of death ably 4 Unknown results prior to make a line of cause death? The cause of death ably 4 Unknown results prior to make a line of cause death? Cyes 2 No | |

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

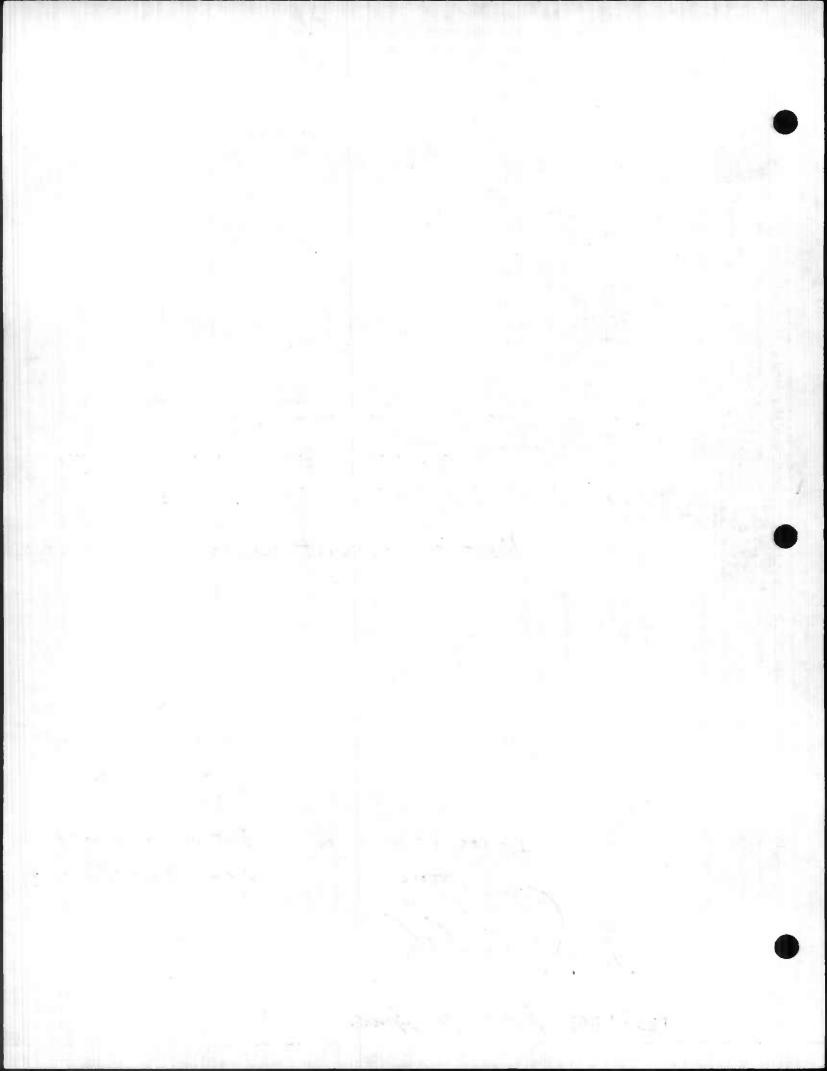
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

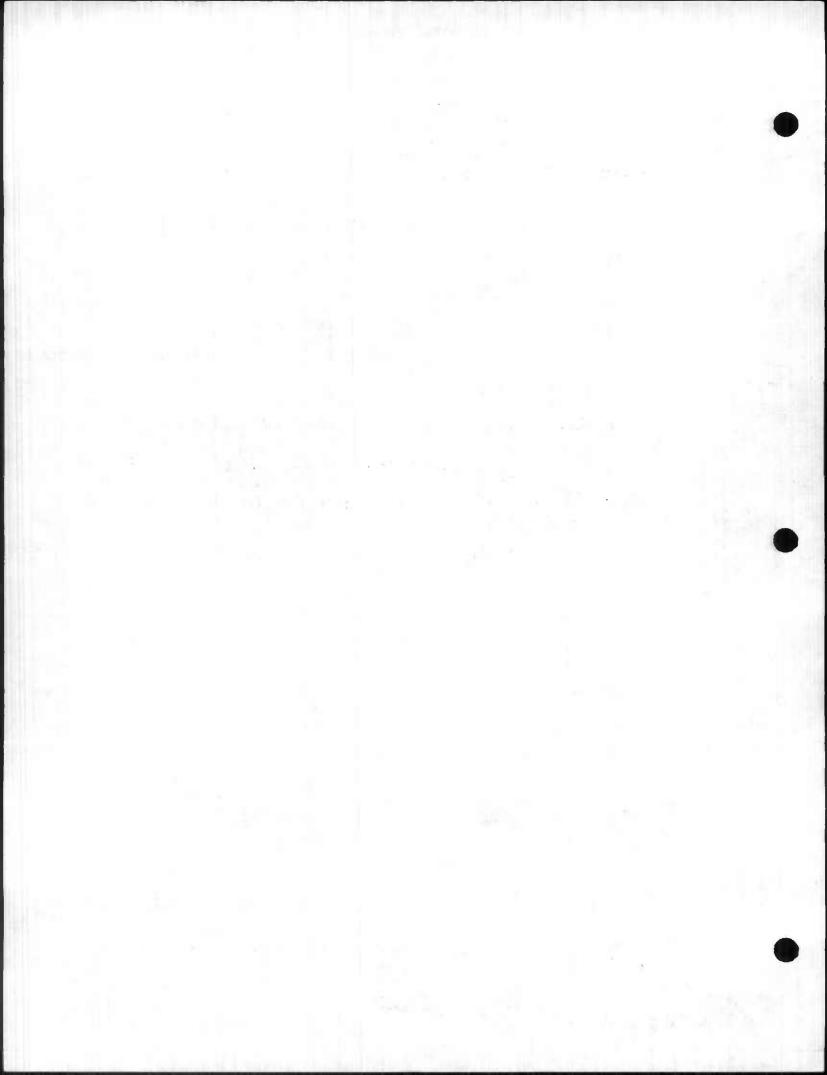
FEBRUARY 8, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 3. Tima of Death 2. Data of Deeth Day Month Year **Physician** RONALD PARK February 03 200 action of Death 4 County of Death 2250 K. 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner BALT/MD RE
If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) HOSPITAL MEMORIAL MOINU 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days 12M 20 F Yrs. 56 Director 560-96-5868 KOREN 10a Steta 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 ☐ Yas 2 ☐ No Director notified MD BALTIMORE COCKETSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 238 1123 DULANEY 21030 U.S.A.

14. Race - American Indian, CIR Funeral GATE 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Merried 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 ğ 3 ☐ Widowed 4 ☐ Divorced KOREAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry filled within U.S. Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12 AUDITOR FEDERAL 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hautt If them 27 is marked oth jury or other traumatic event Be PARK 41 400 JOON JOO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 1123 DULANEY GATE CIE. COCKETSVILLE, MD. 21030 Y. PARK SPOUSE SUSAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State FEB.7, 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) DULAWEY VALLEY M. G. 2000 TIMONIUM, MO 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility EVANS FUNERAL CHAPEL 20 2325 YORK RD. TIMONIUM 21093 liused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onset and Death **Physician** 7-8 month /Medical Immediata Causa (Final Coastric Cancer Metastatic disease or condition resulting in deeth) Examiner Physician/Medical Examiner hysician and the buriel-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): US0 85 signed by the e 23b. Did tobacco usa contributa to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 Yas 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yas 2 ☐ No of Vital or Attending Physicien: director. 25. Was casa referred to medical examinar? Be 26. Placa of Death (Check only ona) 1 ☐ Yas 2 No Hospitat: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 5 Pending invastigation 1 TYes 2 □ No death. 2 Accident the 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2 ŝ 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) 802438946 MODITE person who completed cause of death (Item 23a) (Type, Print) INION MEMORIAL HOSPITAL SOURI 31. Date filed (Month, Day, Year) 32. Registras Signature 11 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFHG782 4/4/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Daeth Month Robert B. Power 3:25 am 10 2000 te 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore harlestown Cave Center If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 5. Social Security Number 3927 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 577-28-3982 Months Days 1 □XM 2 □ F Yrs July 2, 1914 Wash. D.C. Usuel Residenca of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane ST 119 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 XYes 2 No. WWII
If Yes, Give WWII
Year or Dates: 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Auto Damage Elamantary/Secondary (0-12) College (1-4or 5+) Owner/Appraiser Appraisal Company 17. Fethar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Sumama) Walter Power Sylvia Byers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nona C. Power (Wife) 717 Maiden Choice Lane ST 119, Catonsville, MD 21228 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/00 Laurel, Maryland Balto. Washington Crem. 22. Name end Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part 1. Enter the disaase, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina. Immadiata Cause (Final neumonia days diseasa or condition resulting In death) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or as e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 21 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760. Attending Physician: or Attend efter deeth Director: /

obert

within 24 hours a
To the Funeral C

State Registrar

Physician

/Medical

Examiner

Funeral

Director

show

frame 23s or 28s-f show ther must be notified at

Director

Funerai

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Completed

Be

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter deat Depertment of Heelihe and Mental Hygiene. Important: if flem 27 is marked other than any Injury or other traumany.

Physician /Medicai

Examiner

ettending physician and for use as the burief-transit

After this certificate hes

filled in by the

deeth.

Physician/Medical

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Certification:

edical

29b. Signeture end title of cartifier

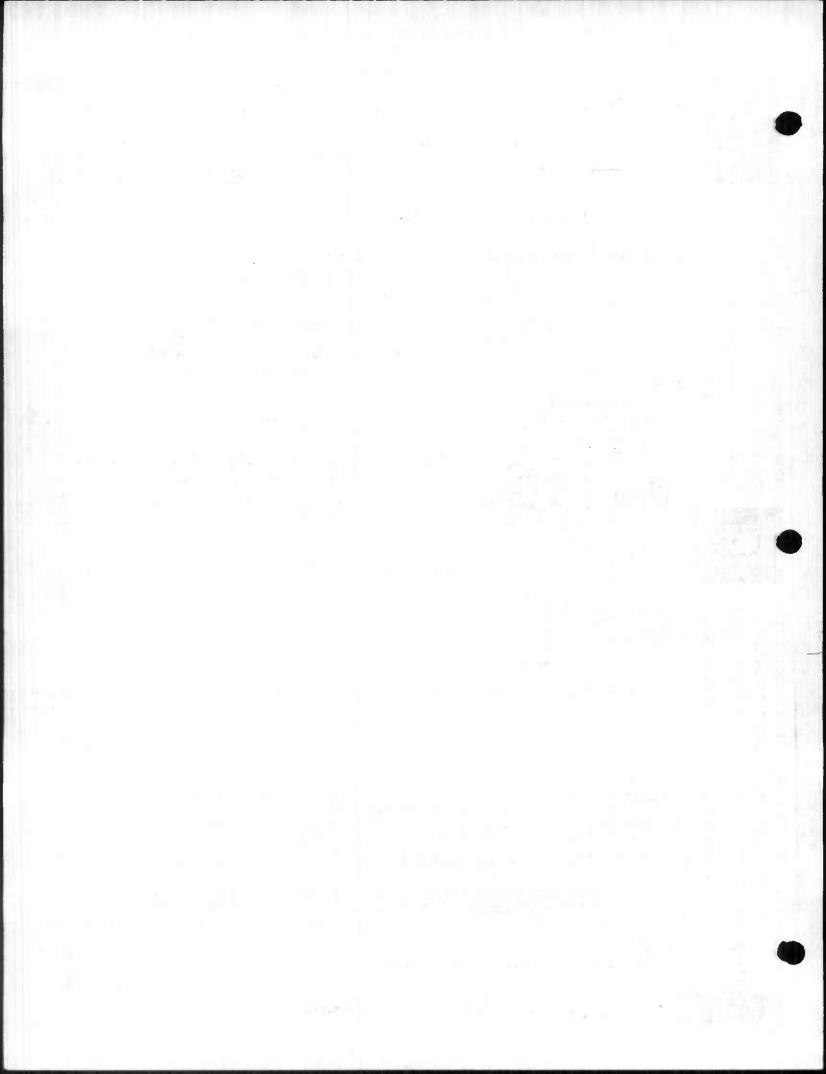
FEB 1 1 2000

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) 34 Data filed (Month, Day, Year)

32. Regisyar's Signature

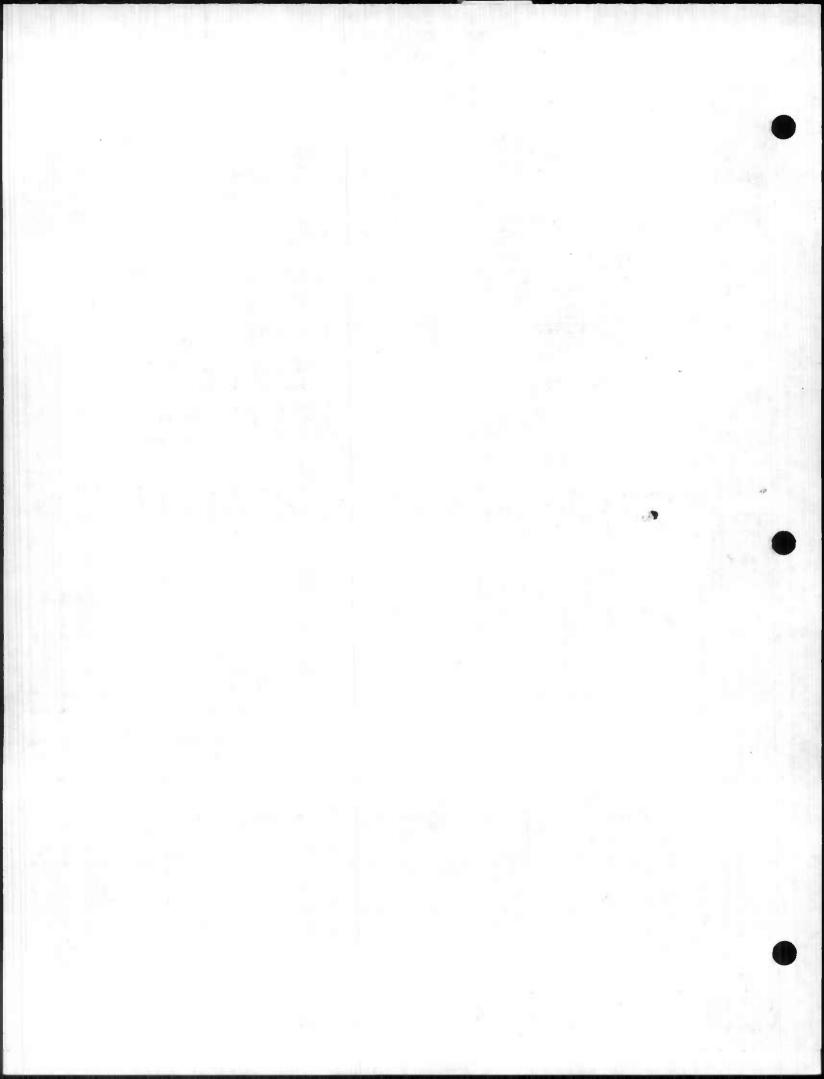
Maiden choice lane, Catous ville, My, 21228
signature & Sparks

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Name (First, Middle, Last) | ficate of Death | Reg | g. No. | 3. Time of Deeth | | | |
|--|--|---|---|---|--|--|--|--|
| Physician | James Jefferson Ridgell, Sr. | | Month | 9, 2000 Year | 3:07 pm | | | |
| /Medical Examiner | 4a Facility Nama (If not institution, giva street and number) | 4b. City, Town, or I | | 4c. County of Death | | | | |
| Laminer | Forest Haven Nursing Facility | Catonsvi | 11e | Baltimor | e | | | |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X Yrs. | | placa (Steta or Foraign intry) yland | | | | | |
| P | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati | | | 10d. Inside City Limits | | | | |
| Ba-f aho | MD Anne Arundel Linthicum | | | XX Yas 2 No | | | | |
| ifter death with the Maint Hern San or 28m fairner must be notified Funeral Director | 109 S. Longcross Road | 21090 | | g. Citizen of What Cou United Sta | | | | |
| permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, the Medical Estational must be notified once. To Be Completed by Funeral Director | 1 Nevar Married 201 Married 1 Tyes 2 No | Decedent of HispanIc Origin? (Sis, specify Cuban, Maxican, Puart Yas 2 No Specify: | pecify Yas or No- o Rican, etc.) | 14. Race - Amer Black, White Specify: Whi | , atc. | | | |
| d 2 should be filed within 72 hours af a 2 should be filed within 72 hours af the marked other than "natural", or traumatic avent, the Medical February To Be Completed by F | (Specify only highest grade completed) (Give kind life. DO | 's Usual Occupation d of work done during most of wor NOT use retired) ervisor | king | 6b. Kind of Business/fr Westinghou Aerospace/ | ise/ | | | |
| ould be filed Mental Hyg arked other atic avant, To Be Co | 17. Father's Name (First, Middle, Last) James J. Ridgell | | ne (First, Middle, Mi n Schwart | eiden Sumeme) | | | | |
| and 2 should ealth and Men n.27 is marke er traumatic | | ddress (Street end Number or Ru Longcross Roa | | | | | | |
| t. Pages 1 ar rtment of Hea rtant: if Itam 2 njury or other | 20e. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemplery, cremetory or other piece) Loudon Park Cemetery 20c. Location - City | | | | | | | |
| permit Depart Import any in | Lou | ame and Addrass of Fecility don Park Funera 0 Wilkens Avenu ne mode of dying, such as cardiac | e, Baltim | ore, Maryl | as Avenue and 21229 Approximete Interval Between Onset and Death | | | |
| Physician /Medical Examiner | Immediate Cause (Final disaese or condition resulting in deeth) s. DiaGeth Mellitum | | | | | | | |
| in d | Due to (or as a consequence of): | | | | | | | |
| physician and s the burishtransit | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c | | | 1 | - | | | |
| bath certificate be an attending physician for use as the burie clan/Medical E | that initiated events resulting in death) Last Due to (or es a consequent d. Ashuyhumi ay | | | /- | | | | |
| d for alter | Part II. Other eignificent conditions contributing to death but not resulting in the under | thing cause given in Part I | 23h Did toh | secco use contribute | to the cause of death' | | | |
| es that the death certifiqued by the attending be detached for use a by Physician/Me | Plant II. Other algumestic conditions contributing to death out not resulting in the under | lying cause given in Part I. | in Part I. 23b. Dld tobacco use contributs to the cau | | | | | |
| The law requires that the death certificate be assected cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examil | | | 24a. Was an perform | ed? a | Vere autopsy findings vailable prior to completion of cause of death? | | | |
| The la | | | 1 ☐ Yes | 2 05 No 1 | □Yas 2)MNo | | | |
| stan: entifice ector, Be C | 25. Was casa referred to medical examinar? | 26. Place of Dea | ath (Check only one |) | | | | |
| nis calling direction | 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpetient 27. Manner of Death 1 Death | 3 DOA Other: 4 Nursing H 28c. Injury et Work? M 1 Yes 2 No | lome 5 Resident | nce 6 Other (Spec v Injury occurred | ify) | | | |
| us or Attanding Phers after death. Solvector: After the fed in by the funeral Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, building, etc. (Specify) | | | | | | | |
| To the Hospital or A within 24 hours after To the Funeral Dire completely filled in D Medical Certif | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death oc and manner stated. | | | | | | | |
| To the To the comp | 29b. Signature and title of certifiar | 29c. License number | 29 | d. Date signed (Month | , Day, Year) | | | |
| 1 | Than foon, M) | 151088 | î | EB 11 | 2000. | | | |
| 4x1 | 30. Nama and address of person who completed cause of death (Item 23a) (Type, Printham Poom 1/20 N ROLLING ROAD, | " Catonsville, | MD 2/3 | 28 | | | | |
| State Registrar | 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | Some | | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month 10th Year **Physician** PAUL RESTIVO 15:20 FEBRUARY 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Hebrew Geriatric Center & Hospital Baltimore If Under 24 Hrs. 6. Sex 1 XM 2 ☐ F If Under 1 Year 8. Dete of Birth (Month, Day, Year) ADK11 5 1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral! Days Months Hours 214-01-0986 Maryland Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Director Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 3903 Brookhill Rd 21215 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filled within 72 hours effer Hygiene. other than "natural; or ite 1 ☐ Yes 2) (No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wh Department of Heelth and Mental Physieru Important: if tem 27 ie marked other tha eny Injury or other treumatic event, that page. Painter Paint Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) B Joseph Restivo Liberto Jennie 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Restivo / Son 726 Faircastle Ave Severna Park, MD 21146 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 2-11-00 Chesapeake Crematory, Inc. Beltsville, MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee CAFA Stephen D. Lohamann, P.A. 23a. Pert T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel PNEUMONIA disease or condition resulting in death) IWEEK Examiner Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE physician and the buriel-transit The lew requires that the death certificate be exacute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, DEMENTIA Physician/Medical Due to (or as e consequence of) 8 for use es DEPRESSION 980 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 WUnknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? should should 24e. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 2 No 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 5 Pending investigation or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: J 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) ofter 4 Homicide within 24 hours efter To the Funerel Direc completely filled in b Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier (Check only one) Within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Sonna M. Eversley MD D0054739 FEBRUARY 10th 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

2434

31. Date filed (Month, Day, Year)

EEB 11

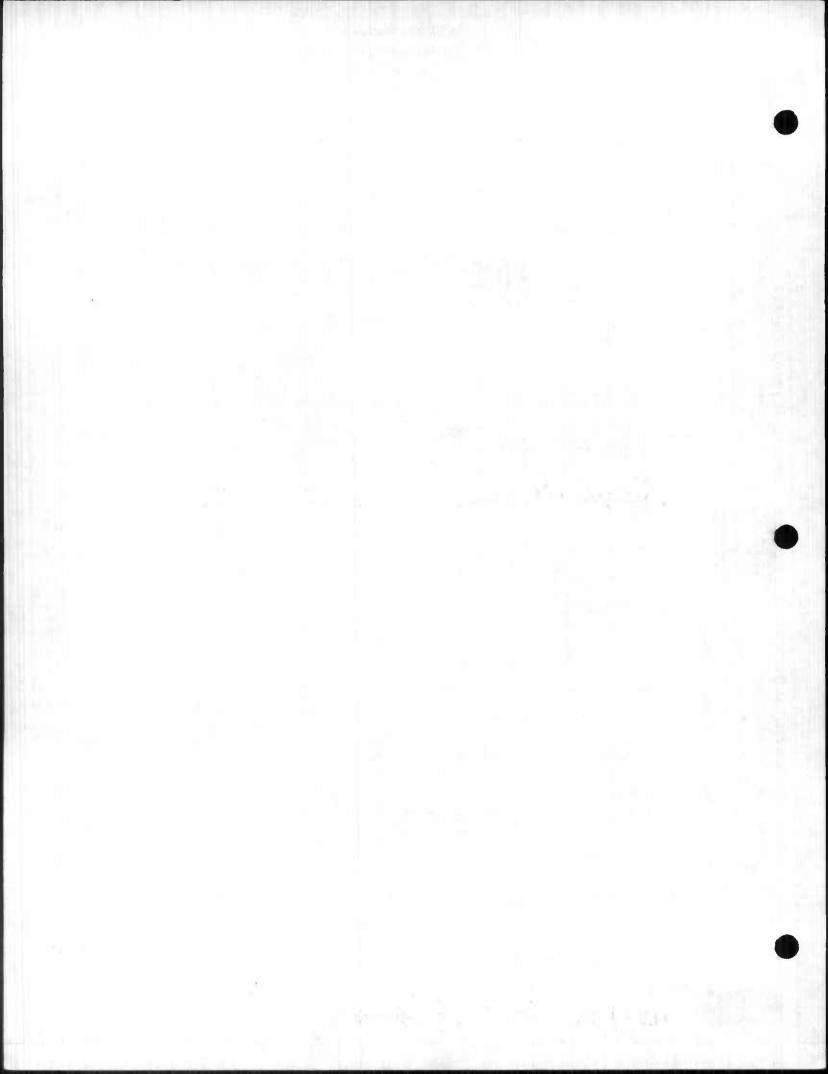
BALTIMORE

MARYLAND

21215

W. BELUEDERE AVENUE

32. Registrar's Signature

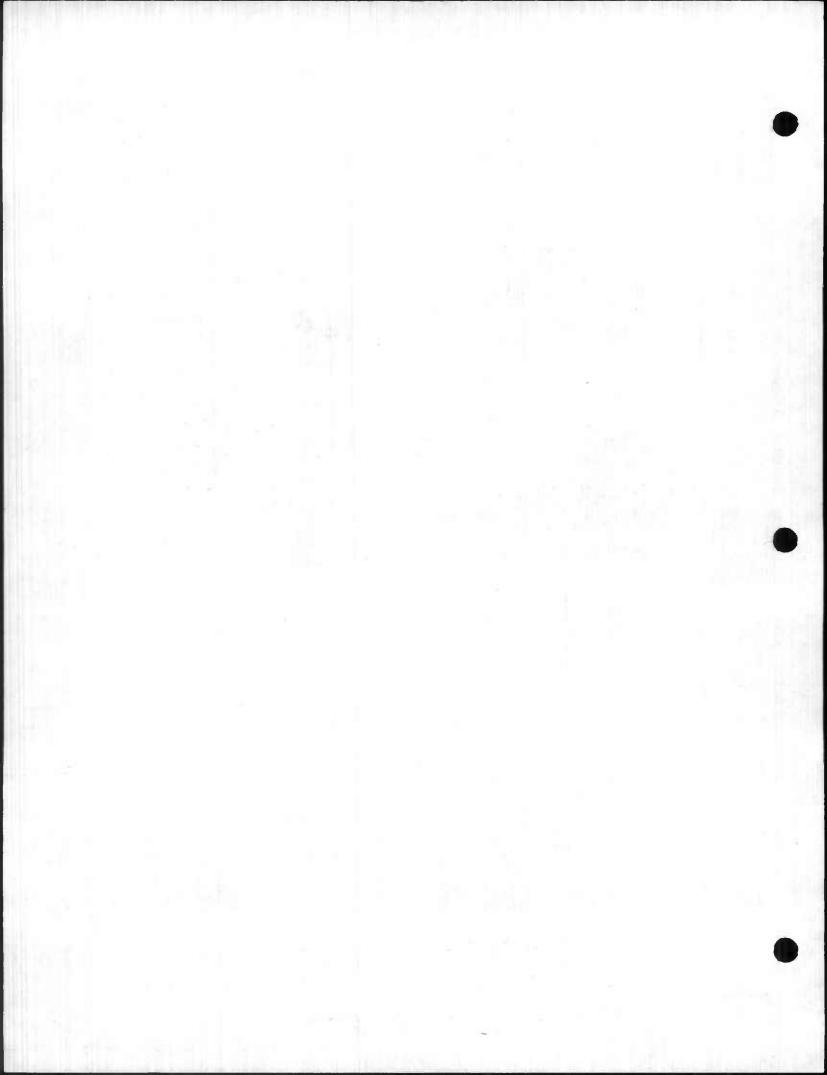


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| | | | (| Certificate of | Death | | Reg. No. | 0 0. | 7611 |
|--|---|--|----------------------|--|--------------------------|--|---|--|--|
| Physician | Decedent'a Name (First, Middle, Last | | | | | 2. Date of D Month | Day Day | Year 3 | 3. Time of Death |
| /Medical | Charles | Ruth | Sr. | | | | 0, 2000 |) | 4:45 AM |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town | , or Location of Dea | ith 4c. County | of Death | |
| | 5 Westminister | Pike | | | Reis | terstown | Balt | imore | |
| Funeral | 5. Social Security Number 6. Se | | yrs. last birth | day) If Under 1 Year Months Days | | Hrs. 8. Date of B | | | e (State or Foreign |
| Director | 212-36-1193 Number of December 1 | DM 2□F 62 | Y | rs. Months Days | Hours | | 0,1938 | | |
| , g . | 10a. State 10b. County | 100 | c. City, Town | or Location | | | | 10d. | Inside City Limits |
| vith the Marylan t or 28a-f show be notified at Director | Md. Baltim | ore | Reis | terstown | | | | | 1 ☐ Yes XXNo |
| | 10e. Street and Number 5 Westministe | r Pike | | 10f. Zip Code | 1201 | | 10g. Citizen of V USA | Vhat Country | 7 |
| Urs sher ari, or he Examine | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. Was Decedent Ever Armed Forces? 1 △ Yes 2 ☐ No If Yes, Give Year or Detes: | in U,S. | 13. Wes Decedent of If Yes, specify Cub | | 7 (Specify Yes or N Puerto Rican, etc.) | | e - American ck, White, etc. White | |
| 5-0 72 hg | 15. Decedent's Edu (Specify only highest grad | cation e completed) | 16a. [| Decedent's Usuel Occu Give kind of work done life. DO NOT use retire | pation during most of | f working | 16b. Kind of Bu | usiness/Indust | try |
| 21215-0 ed within 72 ho ed within 72 ho wer than "naturn 4, the Medical. Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | Salesman | | | Auto | | |
| D Hard | 9 YIS. 17. Fether's Name (First, Middle, Last) | | | | | Name (First, Middl | | (a) | |
| iano id be fi kad od c ever | Francis Ruth | | | | | e Hodges | | 10) | |
| Should should and Mor marks umaric | 19a. Informant's Name/Reletionship (Tr | ma Print) | 10h | Mailing Address (Stree | | | | State Zin Co | ode) |
| Mar d 2 sh th and 7 is m traum | Richard M. Rut | | | | | | | | |
| 1 and 1 and Heath wm 27 other tr | 20a. Method of Disposition | | | 15 Middle Disposition (Name of | poroug | Date | 20c. Location - | | |
| Pages Pages met: # la uny or o | 1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | temovel from State | cemetery | cremetory or other ple Cremator 22. Name and Addr | У | Feb. 1 2000 | | cimore | |
| Demit. Departiment any inj | 21 Signature of Funeful Service Licens | ral Home | of Dur | ndalk | | | | | |
| Physician /Medical | 23a. Pant Enter the disease, or complor heart feilure. List only of Immediate Cause (Final disease or condition | cations that caused the ne cause on each line. | | | ing, such as ca | rdiac or respiratory | arrest, | Int Or | proximate lervel Between inset end Death |
| Examiner | resulting in death) | | | | 2700 | | | | |
| D # E | | COPD | | | | | | - | |
| ificate be executed g physician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | Duade | to (or as a connal U | nsequence of): lcer | | | | 1 | |
| 0 = -= - | resulting in death) Last | Due | to (or es e co | nsequence of): | | | | | |
| death certification of for use a | | | | | | | | | |
| . 0 0 0 | Part II. Other significant conditions cor | ntributing to death but no | t resulting in t | he underlying cause gi | ven in Pert I. | | | | e cause of death? |
| | | | | | | | Yes 2□No | 3 Probeb | ly 4 □ Unknowi |
| is been 2 shou | | | | | | 24a. We | es an autopsy formed? | availa | autopsy findings ble prior to letion of cause th? |
| The it | | | | | | 10 | Yes 20 No | 1 U Y | es 2X No |
| certificate rector, pag | 25. Was cese referred to medical | | | | 26. Place of | Deeth (Check only | one) | - | |
| | axaminer? 1 Yes 2) No | lospitel: | 2 ER/Outr | eatient 3 DOA | hor | ing Home 50 Res | | er (Specify) | |
| E 5 5 5 6 | 27. Manner of Death 1 🗓 Natural 5 🗆 Pending 2 🗎 Accident investigation | 28a. Date of Injury (Month, Day Yes | 28b. Tii | ne of 28c. Inju | | 28d. Describe | e how injury occur | | |
| To the Hospital or Attanding Proting 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - building, etc. (S) | At home, fem | n, street, factory, office | | | ion (Street and Number or Rural Route Number, r Town, State) | | |
| he Hospitu in 24 hours he Funera pletely fills edical C | | ner: On the best of my ner: On the basis of examination and manner steted. | | | | | | | |
| within on the omple | 29b. Signature and title of certifier | . 1 | 1 | 29c. Licen | se number | | 29d. Date signe | d (Month, De) | y, Year) |
| -8-0 |) - south | Q Luc | 1 - | D00 | 24303 | | 2/10/ | 00 | |
| BV | 30. Name and address of person who co | 0 0 | (Item 23a) (T | ype, Print) | BAI | 70 ALA | או ברו ל | | |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar's S | | & Soa | | , one. | 21009 | | |
| Registrar | FFB 1 1 2 | nnn Den | war | H Apa | Nac | | | | - |

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DHMH 16 Rev 6/95



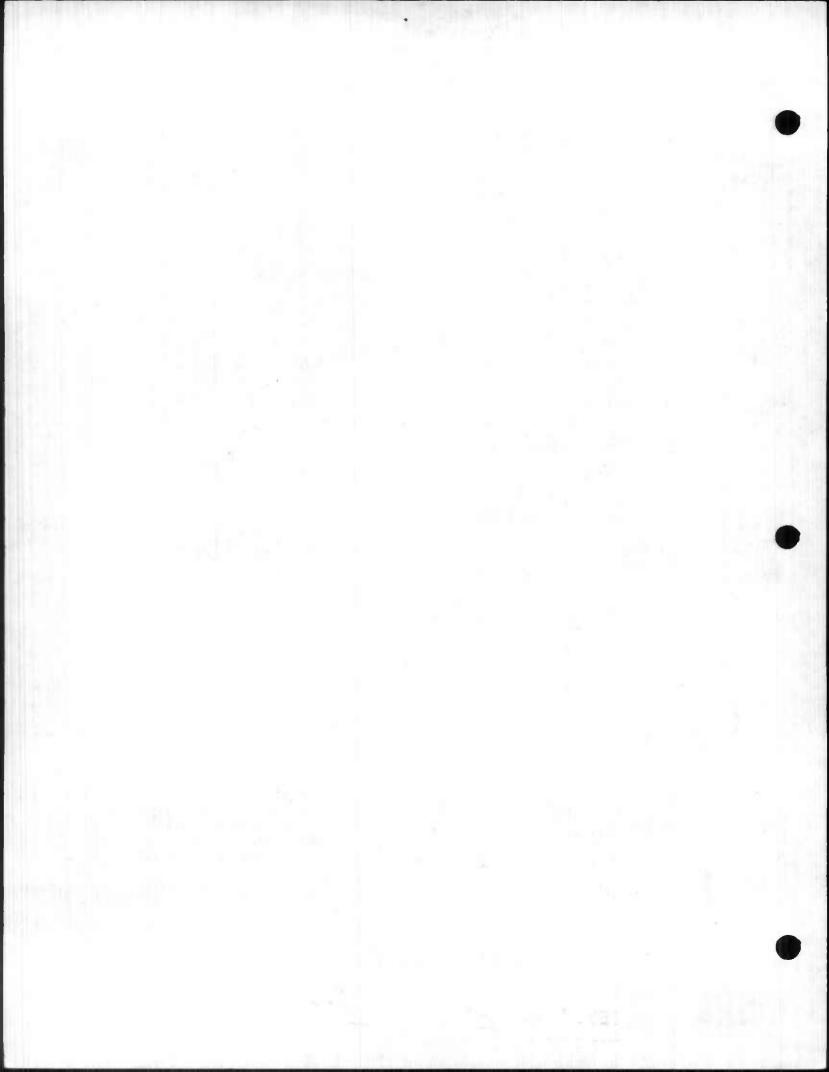
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10, 2000 Year Month **Physician** Feb 6:30pm Jessie Μ. Rosen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Genesis Eldercare Heritage Center Dundalk If Under 1 Year Months Days f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 28, 1904 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F 214-03-4798 95 Md. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md. Baltimore Dundalk notifie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Name 23s or USA 1823 Tyler Rd. 21222 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after wher which of Health and Mentals Hogiens, which if them 37 is merked other than "natural; or the ury or other traumatic event, the Medical Estamina. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Factory 6yrs 17. Father'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 89 George William Garrison Lillie B. Shackleford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Addicks 1823 Tyler Rd. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Sacred Heart Of Jesus Feb 10 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Dundalk 21. Stonature of Funeral Service Licensee 22. Nema and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death **Physician** CEREBROVASCULAR ACUDENT /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner THEROSCLEROTIC CARDIOVASCULAR DISEASE physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HNEMIA Box 68760. Physician/Medical Due to (or as a consequence of) 8 for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 No or Attending Physicien: funeral director, 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 (Naturat To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital TID Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner atlated. edical 29a, Certifie (Check only one) å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bublinae MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Gener FEB 1 1 2000

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary Febuary 7, 2000 4:35pm /Medical 4a Facility Name (I) not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata If Under 24 Hrs. Civista Medical Center Charles 5. Social Security Number 201 - 03 - 9940 If Under 1 Year 7. Age (In yrs. lest birthday) LState or Foreign Date of Birth **Funeral** Days Months Hours 10 M 25 F Director yland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location item 27 is marked other than "natural", or home 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Baltimore 1 □ Yes 2 No Director putua 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? bourne 2 Funeral rit Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race Race - American Indien, Black, White, etc. 11. Merital Stetus permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. In program It flam 27 te marked other than "natural", or then any injury or other traumatic event, the Mental Info 2 Merried 1 Yes 2 No White Specify Specify: by 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College, (1-4or 5+) arian 17- Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Ke4 -atherine rran 19th Meiling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) + 200 St. Mary's Rd. La Plata MD 19e. Informent's Neme/Relationship (Type, Print) Ridge Son 20b. Place of Disposition (Name of permetery, cremetory or other place) 20a. Method of Disposi 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State etro ematory 11100 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecilit Ambrose Fineral Horne uno 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown been signed by should be detac þ 24b. Were autopsy findings eveilable prior to Completed 24a. Was en autopsy performed? completion of cause of death? page 2 1 Yes 2 DiNo 1 ☐ Yes 2 ☐ No toaptal or Attending Physician: The tours after death. Uneral Director: After this certificate by filled in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 (2) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 (DNatural 5 Pending investigation 1 Tes 2 No 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 26a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

altimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

Michael A. Leatherwood.MD 31. Date filed (Month, Day, Year) Registrar

29b. Signeture and title of pertify

32. Registrar's Signature Sparker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

29c. License number

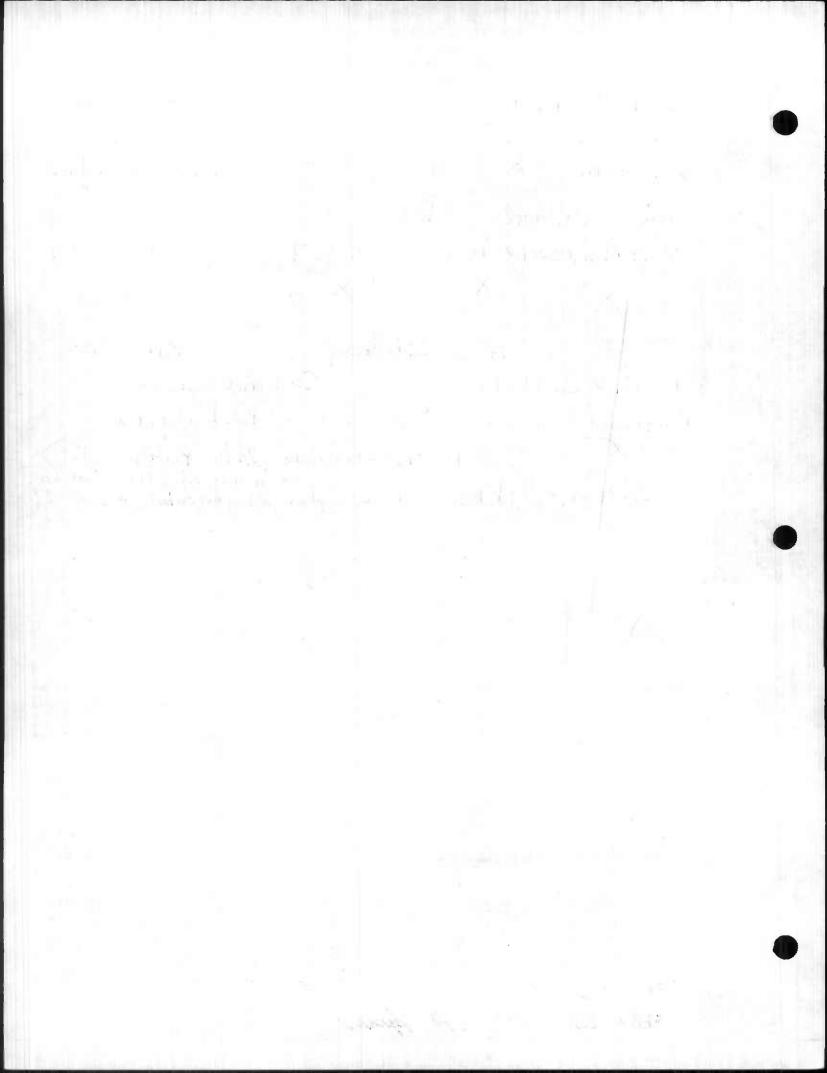
D-21031

12070 Old Line Center,

Waldorf, Maryland 20602

29d. Date signed (Month, Day, Year) 00

Suite 202



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 4, 2000 Reed Delmar 4 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Sky Manor Assisted Living Home H Under 24 Hrs. Hours Min. Min. March 1,1915 If Under 1 Year
Months Days 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) Days 1□M 2ØF 84 217-12-2787 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inaide City Limits 1 Yes 2 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 578 Riverside Drive United States 12. Waa Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ဩ No If Yas, Give Year or Dates: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yea or No If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 Married White 1 ☐ Yas 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Justice Mary Grace Harrison Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, Maryland 21108 247 Severn Road Mrs. Frances Bieman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) Entombment Cedar Hill Cemetery 2/8/2000 Baltimore, Maryland 21. Signature of Funeral Service Con ²², Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart latters. List only one cause on each line. 3204 Mountain Road Pasadena, Maryland 21122 Onset and Death Immediate Ceusa (Final diaease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Onknown accident 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 1 □ Yas 2 ₽ No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Assited Other: 4 Nursing Home 5 Rasidence 6 1 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA living 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

b

Barns 23a

"natural", or

Hygiene.

permit. Pages 1 and 2 should be filled with Capartment of Health and Adental Hygien (Importants if Nem 27 is marked other that any Injury or other the

72 hours after

Baltimore, Maryland 21215-0020

Directo

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Be

Examiner Box 68760, Physician/Medical Records, P.O. þ Completed Division of Vital Attending Physician: 8 Certification: To After To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune

Registrar **DHMH 16 Ray 6/95**

State

edical

denniter Kied 31. Data filed (Month, Day, Year) 1 2000 FEB 1

1 DNaturai

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of conflier

5 Pending investigation

6 ☐ Could not be determined

29c. License number

1 □ Yas 2 □ No

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

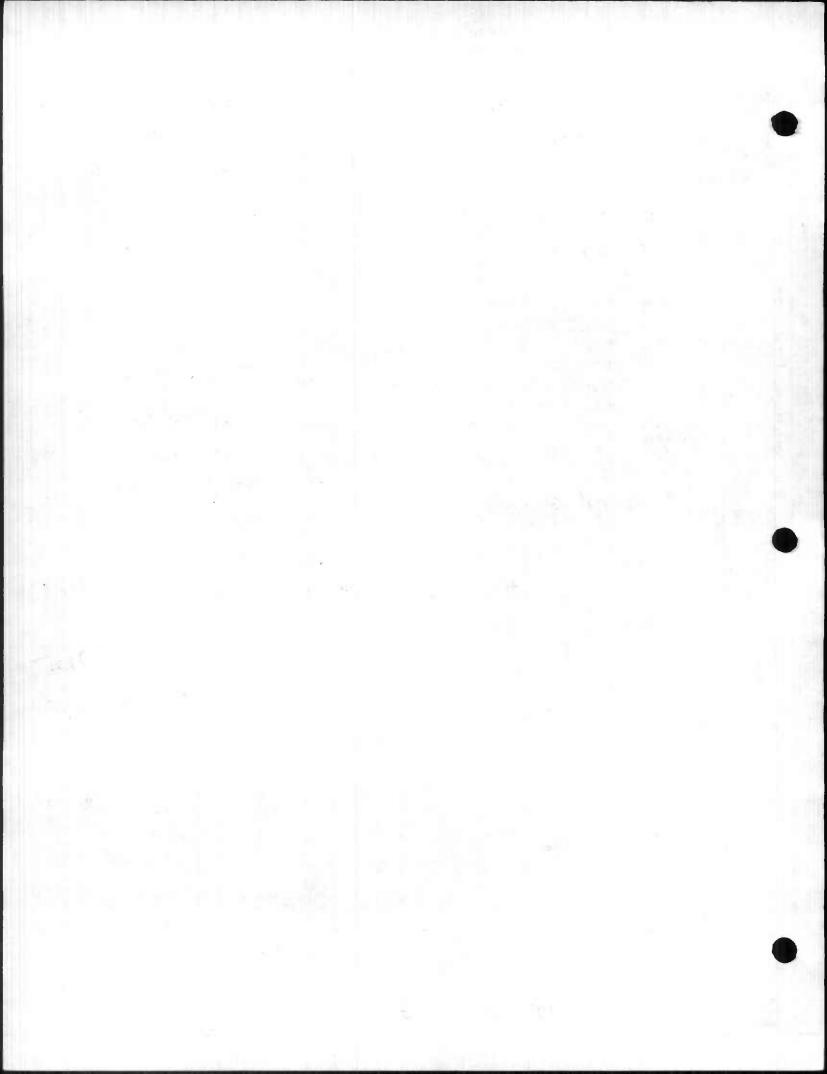
281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Jumpers Hole Severna Park, MD 21146 479 32 Figo strait's Signature

1 🕇 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and mannar as stated



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year Rowley February 5/2000 Donald Jennings 14=30 ths 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Cornell St. - Apt. 412 Aberdeen ford Har If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 6. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. Davs Months 1 M 2 F 217-26-302 maryland 6 July 25,1932 Usual Rasidence of Decedant 10a Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Hartord Aberdeer 10e Streat and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 DYas 2 DNo MYas, Giva Yaar or Datas: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 Yas 208 No Specify: specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) es+AURAN Restaurant 12 0 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Bagley Rowley Roger Jenning 19a. Informant's Name/Ralationship (Type, Print) tta 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3837 Jarrettsville Pike Jarrettsville, MD Theresa (ox - daughte 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State Feb.9, 1 Burlal 2 □ Cramation 3 □ Removal from Stata Donation 5 Othar (Specify) Morel and Mem. Park Baltimore, MDZ1234 22. Nama and Addrass of Facility Evans Funeral Chapet-Bel Air, P.A. 21. Signature of Funaral Sarvice Licensaa Onve 3 Newport P Forest Hill + Qea MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final A SCV D disaasa or condition rasulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part If. Other algorifficant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant Invastigation 6 Could not be datarmined 3 Suicida Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida

attending physician and for use as the bunal-transit The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed by t peeu certificate or Attending Physician: this After after death. To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Be

Funeral

Director

7 is marked other than "natural", or itema 23s or 28a-f show traumatic event, the Medical Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the instantant on the page.

Physician /Medical

Examiner

Physician/Medical

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Medical Certification:

25. Was casa rafarred to medical axaminar? 27. Mannar of Death

29a. Cartifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

29b. Signatura and fitla of certifiar 1 mm

DME

DCME

FEB 5 1h 2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

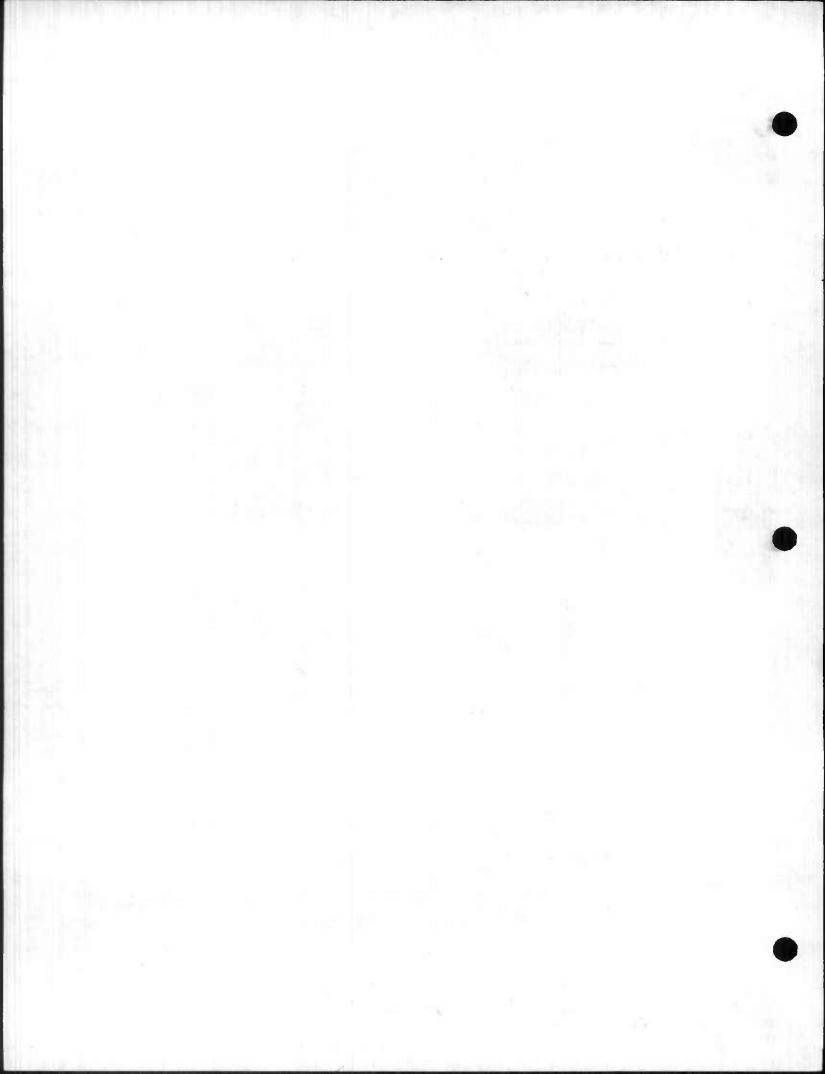
GPRABHU BELANA BELAIR MO 728 31. Data filed (Month, Day, Year) 2. Registrar's Signature

410-879-6564 My 21014

State Registrar

DHMH 16 Rev 6/95

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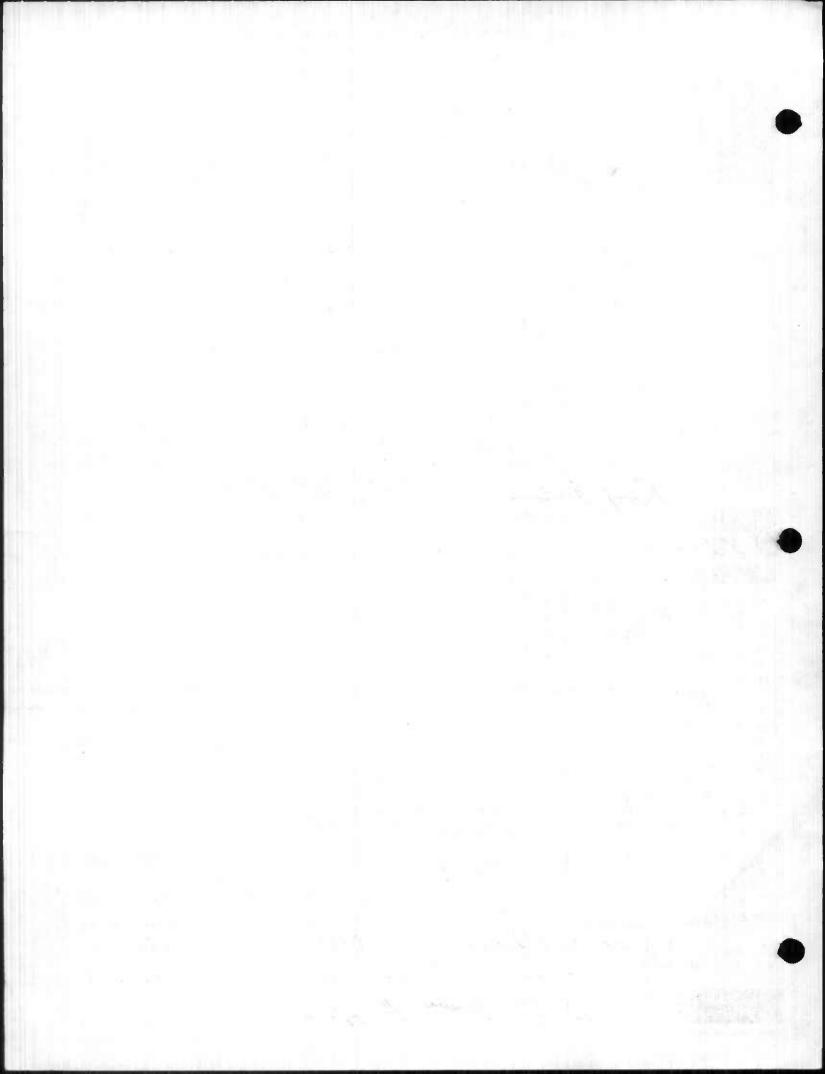
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Month January 24, Eleanor Marquerite Roberts 2000 1:45 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery 5 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 83 251-64-3016 Vre Director Oct. 29, 1916 South Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1250 4th Street, SW #W-407 20024 United States items 23a death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours efter of Mentel Hygiene.
merked other than "natural", or ite 1 Z Yes 2 No If Yes, Give 1943-1966 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Officer permit. Pegas 1 and 2 should be file Department of Haath and Mentel Hy Important: If Item 27 is marked othe eny Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William Neely Roberts Mary Emma Avalona 10 19a. Informant's Neme/Relationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leilani Roberts/Niece 340 Page St., #206 San Francisco, California 94102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 11 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 2000 Arlington, Virginia 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue
Rholl Service Home Bethesda, Inc.
Bethesda, Maryland 20814-3501

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,
Approximate Onset and Death **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Can buriel-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Dire to (or as a consequence of) Physician/Medical the Due to (or as a consequence of) 88 Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Wunknown COPD ģ 2 Completed pege 2 should 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 M No cartificate Hospital or Attending Physician: director. Be 25. Wes cese referred to medical 26. Plece of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D38781 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 11+1 4910 Massachusetts Ave., NW Washington, D.C. Michael J. Grady, M.D. 1 1 2000 Registra's Signature State Registrar

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records.



State of Maryland / Department of Health and Mental Hygiene

| ian | 1. Decedent's Nam | | | | | | | 2. Data of De Month | ath Day | Year 3. T | ima of Death |
|----------------|---|--------------------------|--|---------------------------|------------------------|--------------------------|---|--------------------------------|--------------------|--|---------------------------|
| ical | | Anna Sh | | | | | | January | 20, 20 | 00 12: | 55 pm |
| ner | | | give street and num | | | | 4b. City, Town, or | Location of Death | | | |
| | 5. Social Security P | | scent Cen | ter 7. Age (In yrs. | facet fairtheters) | If Linder 1 Year | Crofton | 9 Date of Die | | Arunde] | |
| П | 165.24.4 Usual Residence of | 711 | 1□M 2∏F | 9 | Special property of | Months Days | | | 31, 190 | 9. Birthplace (5 Country) PA | orara or Foreign |
| | 10a. Stata | 10b. County | | 10c. Ci | ity, Town or Lo | cation | | | - 97 | | ide City Limits |
| Director | MD | | Arundel_ | Od: | enton | | | | | | Yas 2000 |
| 늄 | 10e. Street and Number | | | | | 10f. Zip Code | | | 10g. Citizen of V | What Country? | |
| ara. | | nn Driv | e 12. Was Dece | dest Francis I | 10 10 1 | 21113 | Historia Osisia 0 10 | N | USA | e - American Ind | |
| by Funeral | 11. Marital Status 1 Never Mari | ied 2 Marrie | Armed For | rces? 2[X]No re | | Yes, specify Cut | Hispanic Origin? (S pan, Mexican, Puer Specify: | to Rican, etc.) | | ck, Whita, etc. White | eri, |
| Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | | | | (Give IIIa. C | | pation during most of wo id) | rking | | usinass/Industry | |
| | 12 17. Father's Name | (First Middle 1 | net) | | Но | memaker | 10 Mothada Na | ma (First, Middle, | Own | | |
| o Be | George | | | | | | | | | 10.) | |
| ř | 19a. Informant's N | | | | 19h Mailin | n Address (Street | Agnes | Joanna W | | State 7in Code | |
| | | | rs - Daug | hter | | | , ODento | | | Jiano, 247 0000) | |
| ŀ | 20a. Method of Dis | | 0 | 20b. I | Place of Dispos | sition (Nama of | 1 | Date | | City or Town, St | ata |
| | 1 🗆 Burial 2 | | 3 □Removal from S | Stata | | natory or other pla | 1 | 1/2//00 | | | |
| 1 | 21. Signature F | | | 7 | | ematory Nama and Addr | ess of Facility F | 1/24/00 | Baltim | ore, Mar | yland |
| | | ugon | A Jum | | | | Hwy., S | | | | 1 |
| - | 23a. Part1. Enter I | Gragor he disedse, on | omplications that conformed cause on each | aused the deal | | | | | | | ximete |
| | Immediata Cause disease or condition | (Finel | | UROSEPSI | Sugad | Ane | | | | | el Between t and Death |
| | resulting in death) | | • | | or as a conseq | uence of): | | | | | |
| Examiner | | | - 5 | PROBABLE | RENAL N | EOPLASM | | | | | |
| E | Sequentially list co | nditions, | Ь. | Due to (| or as a consequ | uence of): | | | | | |
| 1 | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events | erlying injury | C | CHF | HF. | | | | | | |
| BOIDS | that initiated events resulting in death) | Last | | Due to (c | or as a consequ | ence of): | | | | | |
| | | | d. | CAD | | | | | | | |
| Physician/M | | | | | | | | | | İ | |
| 2 | Part II. Other signif | icant condition | s contributing to de | ath but not res | sulting in the un | derlying ceusa gi | iven in Part I. | 23b. Did | . 1 | ntribute to the c | |
| | u | inacy | Tract | - mp | ectron | 0 | | 10 | / ` | | 4 Unknown |
| | | heuma | hord & | otur | etis | | | | an autopsy med? | 24b. Were aut available completic of death? | prior to |
| Completed | | | | | | | | 10 | Yes 2 No | 1 ☐ Yes | 2□No |
| 0 | 25. Was case reference examiner? | | Hospital: | | | 1~ | | ath (Check only o | | | |
| | 1 ☐ Yes 2 | | | | ER/Outpatient | 3LI DOA | | loma 5 ☐ Resid | | | |
| 5 | 27. Manner of Deat 1 Shetural | 5 Pending | | of Injury h, Day Year) | 28b. Time of Injury | 28c. tnju Wo | | 28d. Describe I | how injury occur | Ted | |
| Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 2 1170 | 28f. Location (: City or To | | per or Rural Route | a Number, |
| edical C | 29a. Certifier (Check only one) | | Physician: To the la maminer: On the ba and mann | sis of examina | | | | | | | ause(s) |
| | 29b. Signature and | | do . | 0 | | 29c. Licen | se number | | 29d. Date signe | d (Month, Day, Y | ear) |
| | | w | Dililian | () | | - | | | 1/201 | | |
| | 1 | sumua | 4 minu | | | Do | 050872 | | 1/24/ | 2000 | |
| | | | Plumy ho completed cause | | n 23a) (Type, F | | 250872 | | 1/24/ | 2000 | |

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04284 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Year Month 6.30pm Mal Anna IO 0.5 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown Baltimore | North | Days | Hours | Min. | North | Days | Hours | Min. | May 30, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2\F 207-01-8947 81 Yrs. Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Krone Court 21207 IISA 12. Wes Decedent Ever in U,S. Armed Forcee? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Allentown, PA 8 Years College (1-4or 5+) Cafeteria Worker School District 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Paul A.E. Fichter L. Irene Lesher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan Taylor 2204 Krone Court Baltimore, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Greenwood Cemetery 2/11/00 Allentown, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furural Service Licensee 22. Name end Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 23a Part. Enter the dis the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sent feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Hynotense Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or es a consequence of) Chronic at Due to (or es e consequence of): Part II Other significant conditions contribution to indings ause

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Herns 23a

"natural", or Item

permit. Pages 1 and 2 should be filed within 72 hours etter Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural", or he may hitury or other traumete event, the Medical Essenting.

altimore, Maryland 21215-0020

death

Director

Funeral

by

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physician and s the burlet-transit been signed by the should be detached

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

P.O. Box 68760,

Division of Vital Records.

Physician/Medical Examiner by Completed 2 Be edicai Certification: To

| of it. Other argumeant conditions of | Ontributing to death out not re- | sorting in the underlying | cause given in Part I. | 1 □ Yes 2 □ No | 3 Probably 4 Unk | |
|--|----------------------------------|--|------------------------|--------------------------------|--|--|
| | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findir available prior to completion of cause of death? | |
| | | | | 1 ☐ Yes 2 NAO | 1 Yes 2 No | |
| 5. Wes case referred to medical | | | 26. Place of D | eeth (Check only one) | | |
| exeminer? 1 Yes 2 No | Hospitel: 1 Minpatient 2 | 24a. Was an autopsy performed? 24b. Were autopsy findir available prior to completion of cause of death? 1 | | | | |
| 7. Manner of Death 1. Maturel 5 □ Pending 2 □ Accident Investigation | | tnjury | Work? | 28d. Describe how injury occur | rred | |
| 3 Suicide 6 Could not be determined | | nome, farm, street, facto | | | | |

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

[Insert Section 2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier Kauso Pa

29d. Date signed (Month, Day, Year) 29c. License number 02/07/2000 12511

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

KAWAJA 1777

Reisterstown Rd Baltimore HD21208

State Registrar

filled in by the

24 hours e

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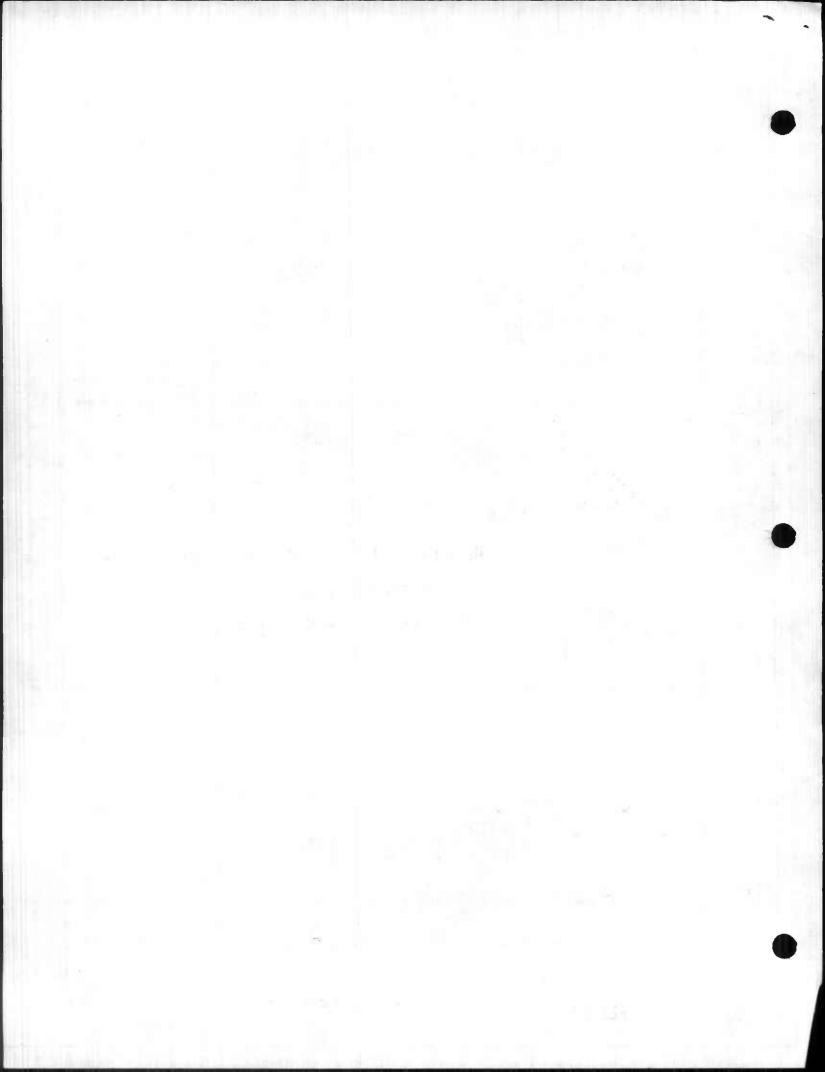
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31. Date filed (Month, Day, Year) FEB 1 1 2000

TAHOORA

32. Registrar's Signature Dener



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Des Month Year JOHN EDWARD SHELDON February 9, 2000 8:55 a.m. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Cromwell Baltimore Baltimore If Under 1 Year 8. Dete of Birth (Month, Day, Year) May 14, 1917 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Days 1X M 2□ F Yrs. 214-05-3064 82 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 North Bend Road 21229 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No H Yas, Give Yeer or Detes: 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: 3 X Widowed 4 □ Divorced White Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) years Machinist BGE (Gas Company) 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) George Sheldon Alice Welling 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Janice E. McAleer (Daughter) 2023 Fallsgrove Way. Fallston. MD 21047 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Louden Park Mausoleum 2/11/00 Baltimore, Maryland 21. Signeture of Funerel Sarvice Licensee 22. Name end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona cause on aach line. Cerebrovascular Accident Immediete Causa (Final 2 months disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted evants resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 740 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 20000 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, State)

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. or Attending Physician: Physician

/Medical

Examiner

Funeral

Director

23s or 28s-f show

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If Health and Mental Hygiens. Important: If Health and St is marked other than "natural", or that any Injury or other traumetic average than "natural", or that

Physician /Medical

Examiner

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page 2 should

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Physician/Medical

Be Completed by

Certification: To

3 Suicide

29a. Certifie

29b. Signati

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30. Neme and address of perso

Saltimore, Maryland 21215-0020

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Completed

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To the Hospital or Attendit within 24 hours after death.

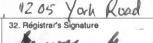
To the Funeral Director: A completely filled in by the fu Medical State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year)

Leavey

MA



tho completed cause of death (Item 23a) (Type, Print)

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Ste 38 Lutyarille My 21093

tifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

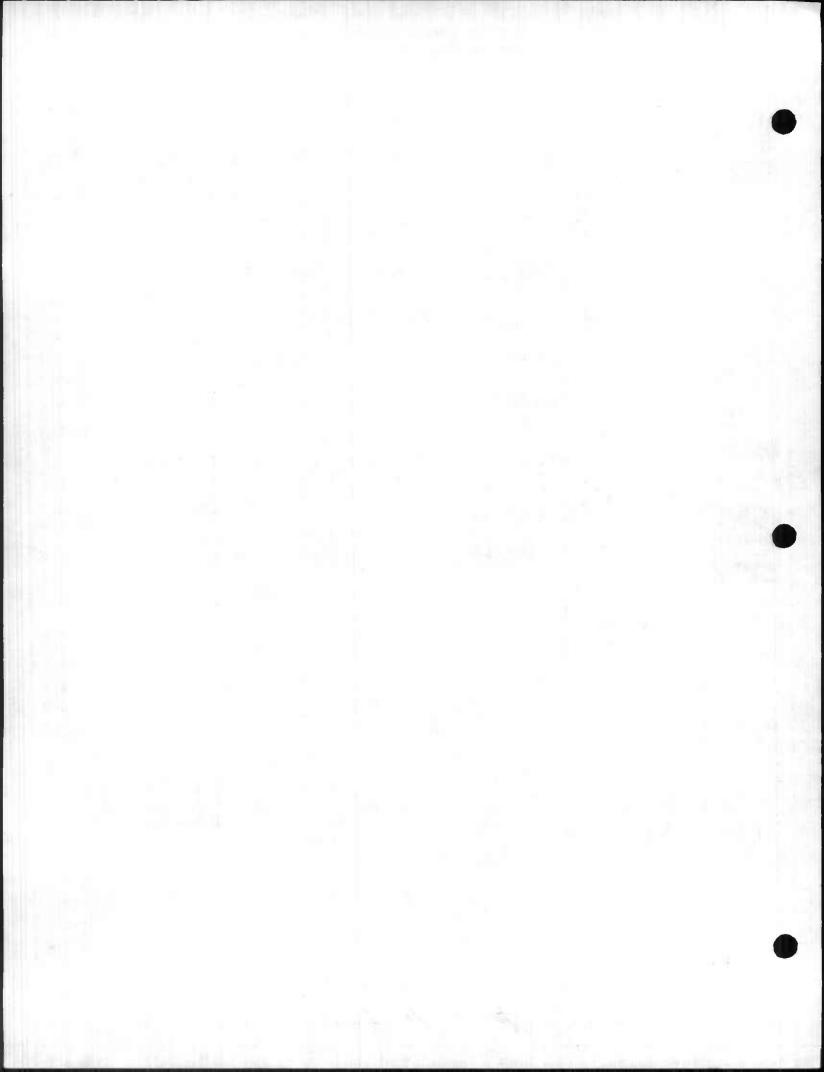
I Mulcai Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

D-17041

29d. Dete signed (Month, Day, Year)

February 10, 2000



G781

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

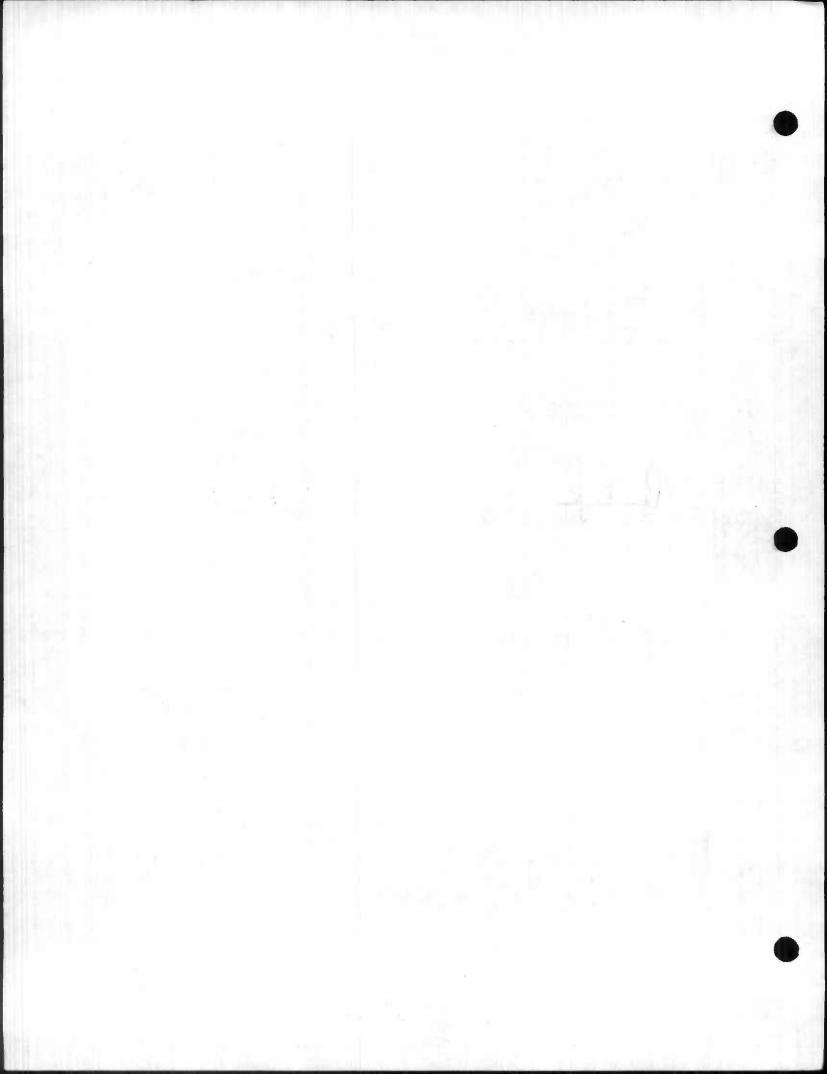
State of Maryland / Department of Health and Mental Hygiene

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| mend | item | 23a.2 | 27 r | er | me | 3/27/00 | V2 |
|-----------|-------|-------|------|----|-----|---------|----|
| I ALL PLA | 10011 | - | | ~~ | 118 | 2/2//00 | 15 |

| icie | | 11 | 1. | 1 | 25 |
|-------|----|-------|----|-----|----|
| | 17 | 0 | 3 | 100 | 0 |
| an Na | | | | | |

| d item 23a,27 | pe | er me 3/27/00 yg | | Certificate of Death Reg. No. | | | | | 04200 | |
|--|------------|---|---|--|---|--|--|-------------------|---------------------|-------------------------------------|
| | _ | I. Decedent's Name (First, Middle, Las | | | 2. Date of Death Month Day Year | | | 3. Time of Death | | |
| Physiciar /Medica | _ | Jordan Allen S | hipley | | | | FEBRU. | , | 2000 | 02:31PM |
| Examine | | la Facility Name (II not Institution, give | | | | 4b. City, Town, or L | ocation of Dea | | of Death | |
| ĝ. | | JOHNS HOPKINS HO | SPITAL | | | BALTIM | ORE | 1 | N/A | |
| Funeral | 5 | i. Social Security Number 6. S | | (In yrs. last birtho | Months Day | | 8. Date of Bi (Month, D | rth | 9. Birthp | place (State or Foreigntry) |
| Director | - 1 | 215-53-8952 1. July 1 Residence of Decedent | ĎM 2□ F 1 | L Yn | 5 Day: | s Hours Mill. | SEPT. | 16,1998 | MAI | RYLAND |
| Pue de ma | - | IOa. State 10b. County | 1 | 10c. City, Town o | r Location | | | | 1 | IOd. Inside City Limit |
| Meryler f ehow | ō I | MARYLAND BALT | TMORE | | COLGATE | 7 | | | | 1 ☐ Yes 2 🕅 N |
| the M | ¥ - | IDe. Street and Number | LITORE | | 10f. Zip Code | - | | 10g. Citizen of V | What Cour | ntry? |
| | | 7747 WYNBROOK ROA | D | | 2 | 1224 | | U. S | Λ | |
| 5 2 | 5 | 1. Marital Status | 12. Was Decedent Ev | ver in U.S. | | | pecify Yes or N | | | can Indian, |
| 2 2 3 | by runeral | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give | | If Yes, specify Cu 1 ☐ Yes 2KIN | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | Rican, etc.) | Specify Specify | ck, White, | etc. HITE |
| A IA IO-UOAU d within 72 hours of glone. or than "neturel; or | | | Year or Dates: | 140.5 | | | | 401 4514 45 | | |
| 2 2 2 | Completed | 15. Decedent's Ed (Specify only highest gra- | | 16a. D | ecedent's Usual Occi live kind of work don | upation e during most of worl ed) | king | 16b. Kind of Bu | JSINOSS/Inc | Justry |
| s within jene. Than | E | Elementary/Secondary (0-12) | College (1-4or 5+) |) " | | | | N7 / | | |
| Hygie | | () 17. Father's Name (First, Middle, Last) | | | DEPENDE | 18. Mother's Nam | o /First Middle | N/A | | |
| A SP | ď | | | | | | | | 10) | |
| should by od Mente | | EARL CHESTER SHIP | | 1.0. | | LISA MA | | | O | 0.41 |
| 2000 | | 19a. Informent's Name/Reletionship (7 | | | | et and Number or Ru | | | | |
| 2 5 5 6 5 | - | MRS. LISA M. SHIPI | EY (MOTHER | | YNBROU isposition (Name of | K ROAD, B | Date | - | | |
| 2 2 2 2 | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other Specify | | cometery, | crematory or other pi | 1 | | BALTIMO | | |
| all Lift Sartmen Sortamt: Injury | 1 | 21. Signature of Funeral Service Licen | 500 | 0121 | 22. Name and Add | ress of Facility | | | , , | |
| D S S S S S S S S S S S S S S S S S S S | | 11. DV | | | | K FUNERAL | | | | 01010 |
| | + | 23a. Part1. Enter the diseas or comp shock, or heart feiture. ist only | dications that caused the | ne death. Do not | anter the mode of the | HMS LANE, | BALTIMO | JRE, MAK | YLANL | Approximate |
| Physician /Medical Examiner | | Immediata Cause (Final disease or condition resulting in death) | MENINGOMYE a. | | THE SPINAL O | | | | | Intervat Between Onset and Death |
| 70 = 5 | ing. | | | ne to los es e cos | isoquerice (ii). | | | | 1 | |
| Cotto be executed physician and it the burlel-transit | Examine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | D | ue to (or as a cor | nsequence of): | | | 1 | | |
| certificate be exiding physician at the burlet. | 9 1 1 | Cause (Disease or Injury that initiated events resulting in death) Last | C. Du | ue to (or as a con | s a consequence of): | | | | 1 | |
| # P = 4 | S | | d | | | | | | | |
| d for u | 5 F | Part II. Other significant conditions or | tributing to death but not resulting in the underlying cause given in Part I. | | | 23b. Did | Tobacco use co | otribute to | o the cause of deat | |
| | | | | soung to death out not too lang in the shooting agreement art. | | | | | | bably 4 Unkno |
| he lew requires the lew requirements that have been required to leave the lew requirements that have leave the lew requirements that have leave the lew requirements that have leave the leave the leave that have leave the leave the leave that have the leave that have leave the leave the l | 200 | | | | | | 24a. Wa | s an autopsy | 24b. W | ere autopsy findings |
| been a should | | | | | | | perf | ormed? | 8V 00 | railable prior to |
| Nes h | Compieted | | | | | | | | | death? |
| | | | | | | | 1)29 | Yas 2□No | 15 | Yes 2□ No |
| oerfilcate medor, per | | 25. Was case referred to medical examiner? | Hospitel: | | 10 | 26. Place of Dea | th (Check only | one) | | |
| F 20 F | - - | (AN) es 2 INO | 1 LI Inpatient | 2 ☐ ER/Outp | Itient 3LI DOA | | | idence 6 Oth | | (y) |
| Atter | 5 2 | 7. Manner of Death 1. Natural 5 □ Pending | 28a. Date of Injury (Month, Day) | Year) 28b. Tim | ry W | | 28d. Describe | how injury occur | red | |
| Start death death the l | 100 | 2 Accident investigation 3 Suicide 6 Could not be | | | | ☐ Yes 2 ☐ No | | | | |
| LIVISION OF Attanding P is after death. It places to the funerated in by the funeration. | | 4 Homicide determined | y - At home, farm (Specify) | , street, factory, office | B | 281. Location City or To | Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| # # # 8 W | 3 | | rsician: To the best of a | | | | | | | |
| To the Fun To the Fun completely | 2 | ane) 2LXMedical Exam | iner: On the basis of ea and manner state | | a areostryation, at my | Operiori, destri occur | HIN OLD IN DO | , cate and prace, | and due to | nia cansa(s) |
| T STORY N | 2 | 29b. Signature and title of certifier | | | 29c. Lice | nse number | | 29d. Date signe | d (Month, | Day, Year) |
| | | YM | 1/1 | | | CME | | FEBRUAF | 2V 8 | 2000 |
| 17 | 3 | 0. Name and address of person who o | completed cause of dea | th (Item 23a) (Ty | | ALTE. | | I DIVONI | 01 | 2000 |
| 1111 | | JACK M. T | Trus mil |) | | n Street, | Baltim | ore. Mai | rvlan | d 21201 |
| State | 3 | 11. Date filed (Month, Day, Year) | 32. Register | s Signature_ | 6 | | LAL CHI | DIC, PICH | اسدر | 4 21201 |
| Registrar | | FEB 1 1 | 2000 1 | perme | p. pp | acts | | | | |
| | | | | | | aT. | | | | |



Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

s 1 and 2 should be filed within 72 hours efter death with af Health and Mental Physiens or them 27 la marked other than "naturel", or items 23a or other transmittic event, its finding to control transmitter must be a other transmitter and the second of the transmitter and the second of the transmitter and the second of the transmitter and the second of the transmitter and the second of the

Director

Funeral

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Completed

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Peges 1 en. ment of Health en important: If It any injury or c 21. Signeture of Funeral Service Licensee 23a. Pen1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Physician /Medical Immediete Ceuse (Finei disease or condition resulting in deeth) e. Aspiration pneumonia Examiner Due to (or es e consequence of): Examiner physicien and the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760. Physician/Medical Due to (or es e consequence of) 80 use signed by the a Records, P.O. coronary artery heart disease þ Completed pege 2 certificate Division of Vital Physician: 25. Wes case referred to medical exeminer? Be Hospital 2 1 ☐ Yes 2 ☑ No 1☑ Inpatient 2□ ER/Outpetient 3□ DOA this 28a. Date of Injury (Month, Day Year) luneral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: or Attanding 5 Pending investigation efter death. Director: Al 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide filled in by 4 Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fl (Check only one) 29b. Signature and title of certifie w 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Robert A. Palermo, 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey F SCHMELZER SR. **JOHN** February 08, 2000 06:55 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec. 23 1916 Birthplace (State or Foreign Country)
 MAryland 5. Social Security Number 7. Age (In yrs. lest birthdey) Months Deys Hours Min 1⊠M 2□ F 216-03-0340 Yrs 83 Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Middle River 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1346 Burke Road 21220 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Western Electric 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JOseph Schmelzer Agnes Willschlager 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Gladys Schmelzer / wife 1346 Burke Road Baltimore Md. 21220 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 2/12/2000 Baltimore Md. 22. Name end Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 Approximete Intervel Between Onset and Deeth to not enter the mode of dying, such as cardiac or respiratory errest, weeks

Transitional cell carcinoma of bladder and

prostatic adenocarcinoma Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24e. Wes en eutopsy performed? 1 ▼Yes 2 No

26. Place of Deeth (Check only one)

1 Tyes 2 □ No

28e. Plece of Injury · At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

02/09/2000

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of ceuse of deeth?

1 No Yes 2 No

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Day, Year)

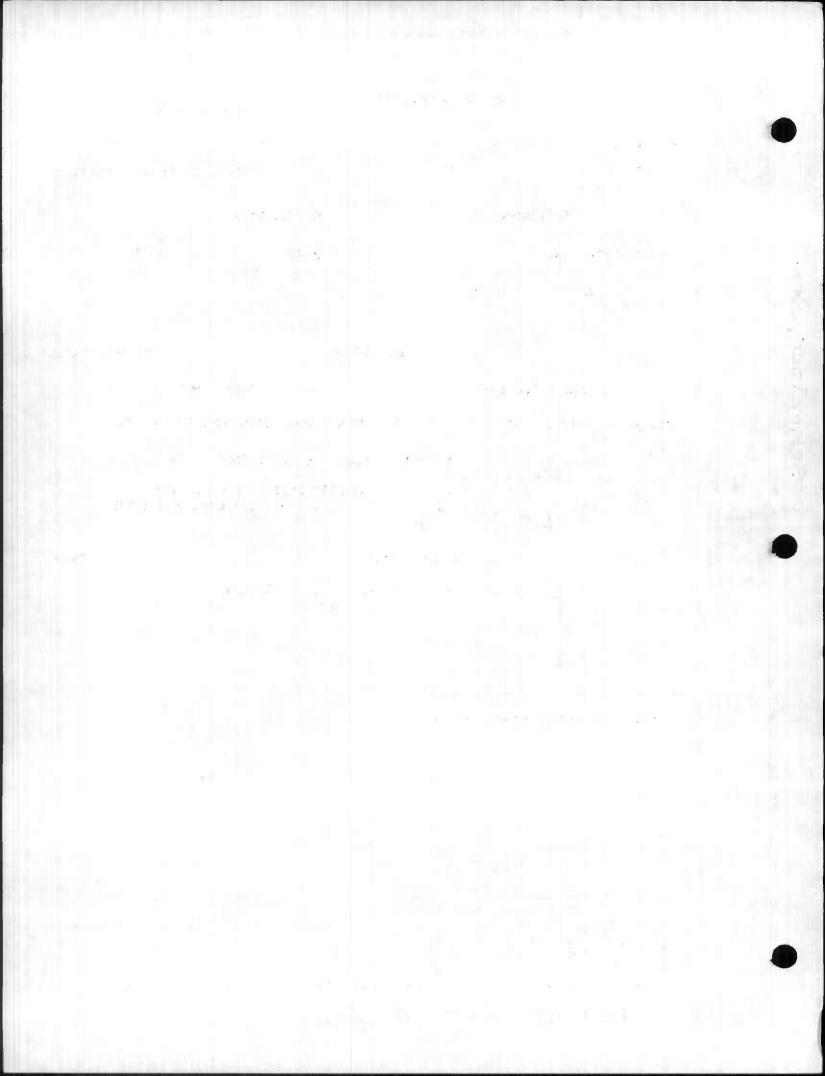
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M.D. - GBMC 6701 N Charles St., Baltimore, MD

Registrar

1 1 2000 FEB

DHMH 16 Rev 6/95



Please Type or Print in Biack indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 11:15 AM 2000 FEBRUARY 6, SCHUMAN ANDREW 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) MARINER HEALTH AT NORTH ARUNDEL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Sex MM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 86 Yrs. 216-05-5425 AUG. 10, 1913 MARYLAND Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2√ No MARYLAND ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 MAPLE AVENUE 21061 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status X Yes 2 No 1940-If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER STATE OF MARYLAND 7 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM SCHUMAN JOSEPHINE DILLMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) ROBERT BINGEL, SR. SON-IN-LAW 102 MAPLE AVENUE, GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/9/2000 20c. Location - City or Town, State 1 Buriet 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Michael L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): ement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

physician s the burial Box 68760, P.O. Records, certificate Division of Vital this Ne Hospital or Attending P in 24 hours after death. Ne Funeral Director: After t After

Physician/Medical þ Completed Be

Physician

/Medical

Examiner

Funeral

Director

r 28a-1 show notified at ahow

or flams 23a or

Hygiens.

permit. Pages 1 and 2 should be this Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumetic event

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Medical Examiner must be

Director

Funeral

À

Completed

Be

To the I within 2 State

DHMH 16 Ray 6/95

Registrar

31. Date filed (Month, Day, Year) FEB 1 1 2000

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only

Calen Burnie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 201 Crain Towers

Md. 21061 oaks

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

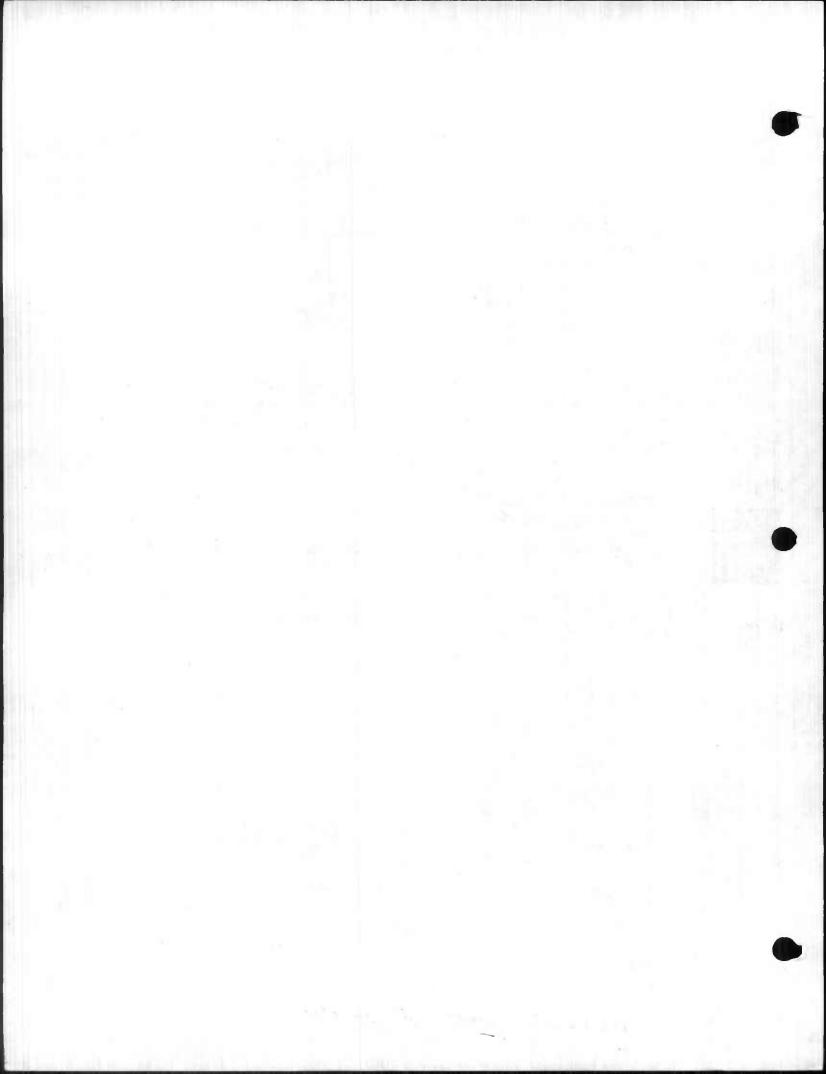
29c. License number

D14136

281. Location (Street and Number or Rural Route Number, City or Town, State)

2/08

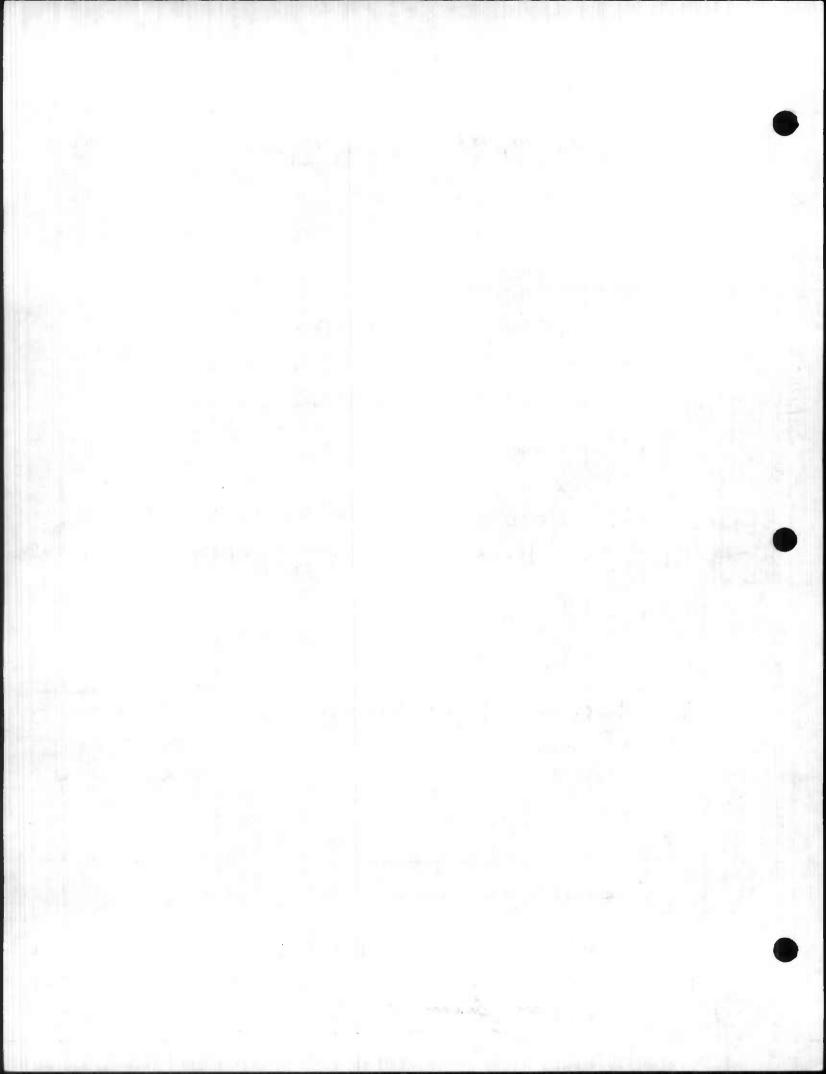
29d. Date signed (Mopth, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Physician Febusa 407m John F. Schmitz Sr. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner FRUNde DITA 5. Social Security Number If Under 1 Yaar Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 10 M 20 F 219-22-6177 Yrs. 71 Director 09 Maryland Usual Residence of Decedent 10a Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiana.

ant: If Itam 27 is marked other then "natural; or forms 23a or ; ury or other traumatic avent, the Medical Exeminar must be it. 234 Twin Beach Road 21122 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11, Marital Status 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 1 □ Never Married 2 N Merried 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Chemical Corporation 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) John P. Schmitz Louise Runk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Twin Beach Road, Dolores Schmitz (wife) Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If It any Injury or o pncs. 1 □XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Si 22. Nama and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest Physician Cardionyopato Immedieta Causa (Final diseasa or condition resulting in death) /Medical more Houn Ty, Examiner Due to (or as a consequence of) Physician/Medical Examin attending physician and for use as the burlal-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 35 Probably 4 Unknown Division of Vital Records, Medical Certification: To Be Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 28 No or Attanding Physician: 25. Was casa referred to medical 26. Place of Deeth (Check only one) 1 Yas 25 No Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Sunpatient 2 ☐ ER/Outpatient 3 DOA the th funaral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending invastigation s after death.
I Director: Aft
od in by the fur 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) filled in by 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D completaly filled **Sertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mennar as stated.

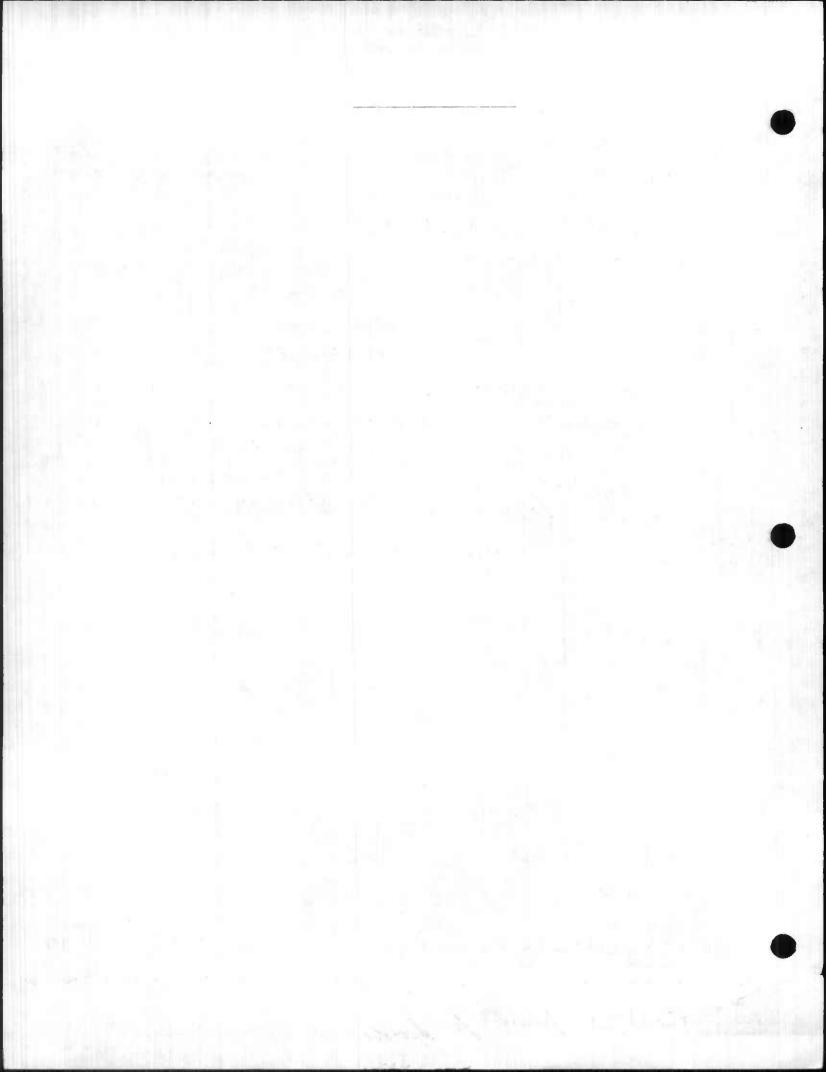
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and mannar stated. 29a. Certifier 29b. Signature/and title of cad 29c. License number 29d. Data signed (Month, Day, Year) m_{1} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Im IJumie, mD :21061 BUHITET 301 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State FEB 1 1 2000 Registrar



ORIGINAL

2000

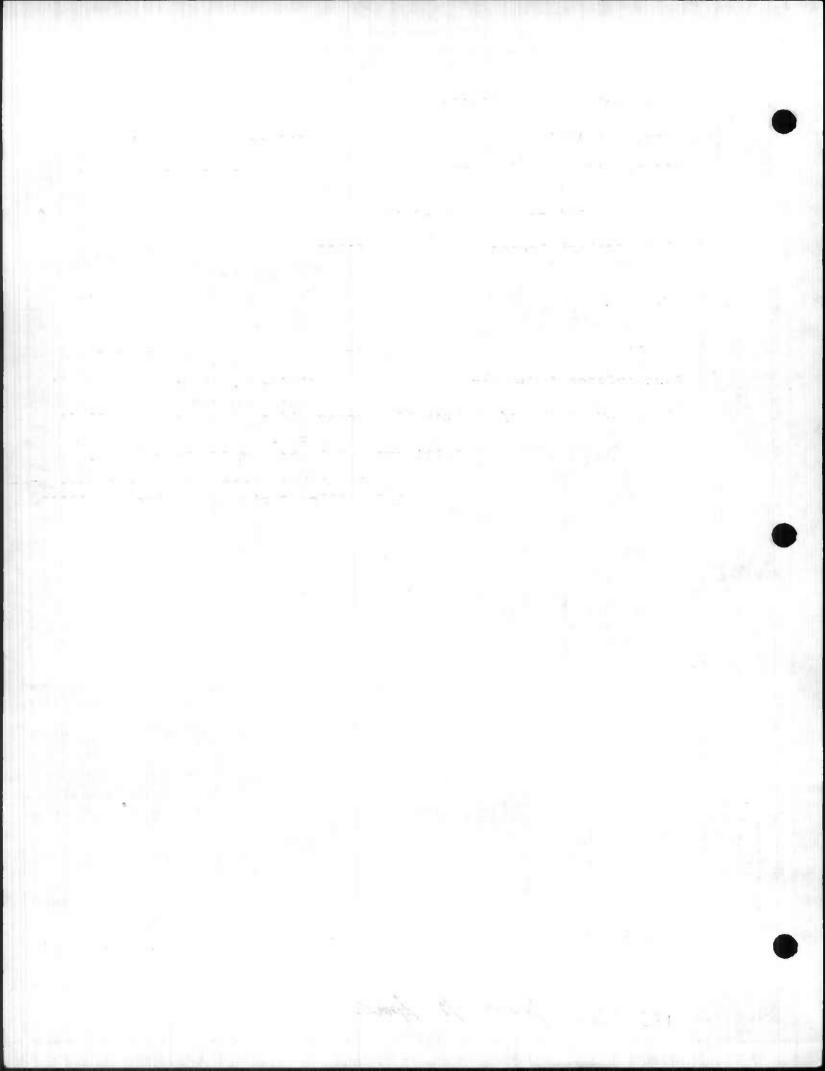
SANTANGELO



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death EBRUARY 8,2000 Day **Physician** Margaret Schlaile /Medical Ac. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Mercy Hospital Baltimore If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months 1 M 200F Yrs 215-30-7064 Director 79 Md Usual Rasidence of Dacedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 No Director Md Baltimore Dundalk 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8100 Rosebank Avenue 21222 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuben, Maxican, Puerto Rican, atc.) Heme 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, White, atc. 11 Marital Status filed within 72 hours after 1 Never Marriad 2 Married ☐ Yas 2 No f Yas, Giva natural', or Baitimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth end Mentel thygient Important: If frem 27 is marked other the any Injury or other treumatic event, the pages. 10 Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Independence C Kuemmer Gladys B. Keyes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Gladys Ernstberger/daughter 228 Booger Ridge Rd, Swanton, Md21561 20b. Place of Disposition (Nama of 20a. Method of Disposition Data 20c. Location - City or Town, Stata cematary, crematory or other placeCrem . 1 Burial 2 Cramation 3 Ramoval from State Baltimore-Washington 4 Donation 5 Othar (Specify) 02 12 Laurel, Md. 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility Bradley-Ashton-Matthews Funeral Home, Ind 2134 Willow Spring Rd, Balto, Md

23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21222 Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final to lirain a lungs disaasa or condition resulting in daath) **Examiner** Dua to (or as a consequence of) Examiner that the death certificate be executed physicien and Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 No 1 Yas 2 No certificate Division of Vitai Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) STELLA MARIS AT Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) HOS DIC 1 Yas 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injuly occurred 28b. Tima of i B Natural 5 Pending Invastigation 1 Yas 2 No 20 Accidant 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 | Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 45 Contifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the bests of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) D40854 M 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) BAH, MORE, MD 21202 30 31. Data lifed (Month, Day, Year) 62. Registrar's Signatura State Registrar FEB



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician February 1:15 AM Linda 2000 Ann Schumann /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 20 F Months Yrs. 220-60-9988 48 Director 05 08 1951 Md Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow 1 Yes 2 No Md Directo Baltimore 28a-f Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 4 Mountain Green Circle 21244 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Mems al Hygiene, coher then "natural", or heme event, the Medical Examiner or Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int. If Nem 27 Is marked other then "natural", or he 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 KNo Specify: þ 3 Widowed 4 Divorced white Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator College Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter K. Zimmerman Frances G. Zanto 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Hern 27 is or other tra Russell Schumann/husband Mountain Green Circle Woodlawn, Md 21244

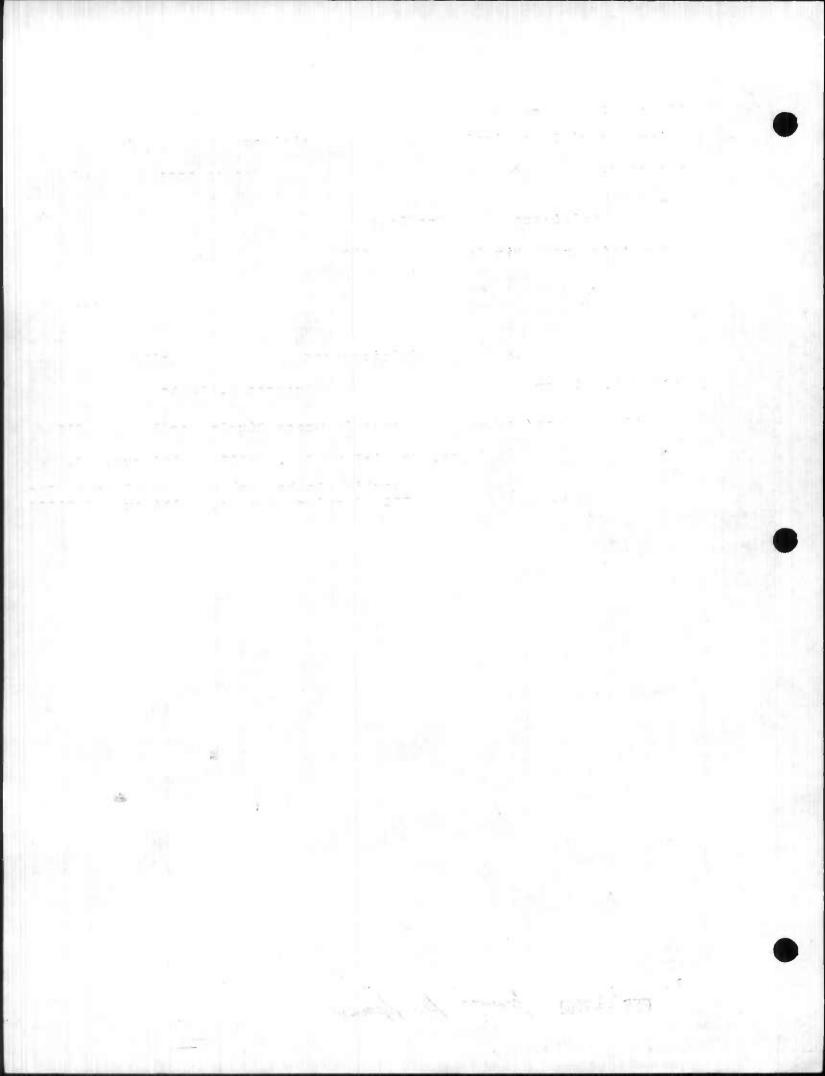
Moisposition (Name of Date 20c. Location - City or Town, State 4 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremetion 3 Removel from State Department of Important: If any injury or St. Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 0212 Baltimore, Md. 22. Name and Address of Facility
Sterling-Ashton-Schwab Funeral Home, Inc 21. Signature of Funeral Service Licens Brry 736 Edmondson Avenue, Baltimore, Md 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, auch es cardiac or respiratory arrest, shock, or heart feilurit. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 5 days Tumor Lysis Syndrome disease or condition resulting in death) Examiner Physician/Medical Examiner Acute Renal failure 5 days The law requires that the death certificata be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Box 68760, Ovarian Cancer the Due to (or as a consequence of): U88 88 signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 ☐ No After this certificata or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 | Yes 2 | No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date aigned (Month, Day, Year) February 9, 2000 8TZ438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL, BALTIMORE, MD Mc Cusker MARGARET 32 Begistra Signature State

DHMH 16 Ray 6/95

Registrar



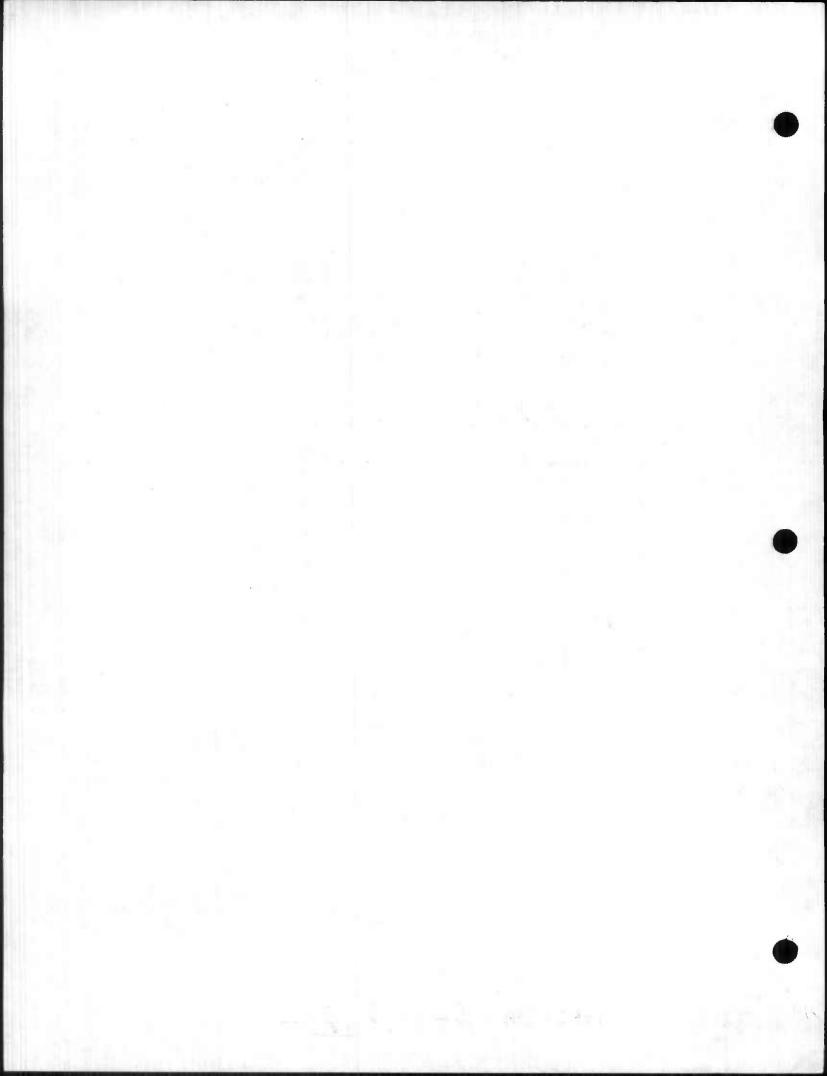
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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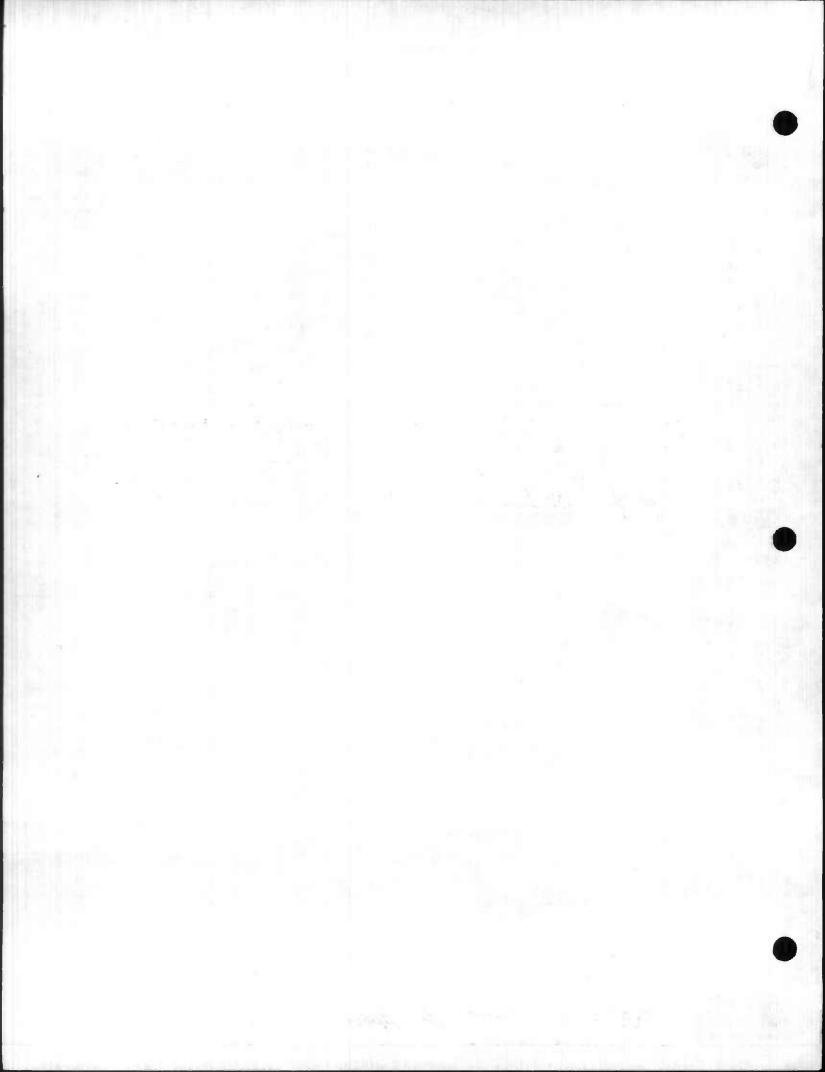
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| Director | 10e. Street and Nu | ımber | | | | 10f. Zip C | oda | | | | 10g. | Citizen of \ | | ntry? |
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| Funeral | 11. Marital Status | | 12. Was Dec | edent Ever in U orcas? | J,S. 13. | Was Decedar It Yas, specify | nt of Hi | spanic Origin, Maxican, | in? (Spe Puerto | Rican, ato | or No- | | ce - Amaric ck, Whita, | can Indian, etc. |
| | | ried 2 Married | 1 ☑ Yes If Yas, Gi | 2□No va | | 1 ☐ Yas 20 | | | | | | Specifi | Whi | +0 |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 8^{Dey} **Physician** Ernest Taylor 13:25pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA 1201 Broening Highway Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-17-46 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Days Months 53 214-44-8253 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore X X Yes 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 frame 23a or iner must be 1201 Broening Highway USA 21224 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Merried "natural", or it Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education ify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest se filed within 7 tal Hygiene. d other than "y event, the May College (1-4or 5+) 8th Grade (0-12) Line Worker Ivy Steel &Wire Co 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 Important: If Item 27 is marked of any Injury or other traumatic eve Elmore Young Irene Taylor 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a. Informant's Neme/Reletionship (Type, Print) Marion Taylor 1201 Broening Highway Baltimore, Maryland 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel Irom State Voshell Mem. Gardens 02-11-2000 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses March F.H. East 1101 E. North Ave. Ulre that he disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, the int failure. List only one cause on each line. 23a. Faft1. Entr Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Bowel adencaruser year Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): US0 88 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 Inko 3 Probably 4 Unknown Records. 2 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? cartificate has page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Physicien: 8 25. Wes case referred to medical examiner? funeral director 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatien1 3 DOA Certification: To After this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 C Natural a after deeth. 1 ☐ Yes 2 ☐ No the 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fl (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) witos Mulan 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BATTER AVE BALTIMOR MI 21224 PURRI JYBVML MILHARL 4940 31. Date liled (Month, Day, Year) 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year WILLIE **Physician** MAE THOMAS 12.59 Am Feb 2000 06 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ballimore Healthcare St Agnes NA Hours Min. 8. Date of Birth (Month, Day Year) Sep 04 1933 7. Age (In yrs. last birthday) If Under 1 Year 9 Birtholace (State or Foreign **Funeral** Days Months Country) 10 M 20 F 66 **Director** Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or flams 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at MD NA BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 608 DENISON STREET 21229 USA death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes. 2☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: BLACK P 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72 Department of Heath and Mental Hygiene. Important: if hem 27 is marked other train "natu bits. Elementary/Secondary (0-12) College (1-4or 5+) 8th DOMESTIC AT HOMES 17. Father's Nama (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumeme) DORSEY SMITH MARY MCBRIDE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA LAYTON - DAUGHTER 2749 RIGGS AVE. BALTIMORE, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) WOODLAWN CEMETERY 2/10/2000 BALTIMORE CO. m of Funeral Service Licen MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., 21215 23a. Part. Enter the visionse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shorts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Sephic disease or condition resulting in death) Examiner 3 month Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) gland 3 months attending physician Physician/Medical ě Due to (or as a consequence of): 10 days Ventro penio Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 2 Unknown signed by 1 ☐ Yes 2 ☐ No adeno caramina uterme 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) To Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Affact Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide affer 24 hours 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the F 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. P12595 Feb 06, 2000 caton Avenue timore, MD 21228. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Mallah M.D. Mustapha Baltimore, 31. Date filed (Month, Day, Year) FEBII 32. Registrar's Signature State 2000

DHMH 16 Ray 6/95

Registrar

Thomas

ocks

Dener

Md - wel

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

Name 23a or 28a-f show

8

Hygiene.

Department of Health and Mental Important: If Nem 27 is marked o

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Physician/Medical the 0 this death. To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi

| that initiated events resulting in death) Last | Due to (d | or es a consequence of) | : | | |
|---|--|-----------------------------|---------------------------------------|---|--|
| Pert II. Other significant conditions of | entributing to death but not re- | sulting in the underlying | cause given in Part I. | 23b. Did tobacco uee co | ntribute to the cause of death? 3 □ Probably 4 ② ₩ nknow |
| | | | | 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| | | | | 1□ Yes 2□ No | t ☐ Yes 2 ☐ No |
| 25. Was case referred to medical examiner? | 41 | | | eth (Check only one) | |
| 1 ☐ Yes 2 ☑ No | Hospitel: 1 ☐ Inpatient 2 ☑ | ER/Outpatient 3 D | OA Other: 4 Nursing | Home 5 ☐ Residence 8 ☐ Oth | ner (Specify) |
| 27. Manner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigation | | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occur | red |
| 3 Suicide 6 Could not be 4 Homicide determined | 28e. Plece of Injury - At h building, etc. (Speci | nome, ferm, atreet, fecto | ry, office | 281. Location (Street and Numb City or Town, State) | ber or Rural Route Number, |
| | | | | e, end due to the cause(s) and mourred et the time, date and place, | |
| 29h Signature and title of certifier | | 29 | c. License number | 29d. Dete signe | d (Month. Day, Year) |

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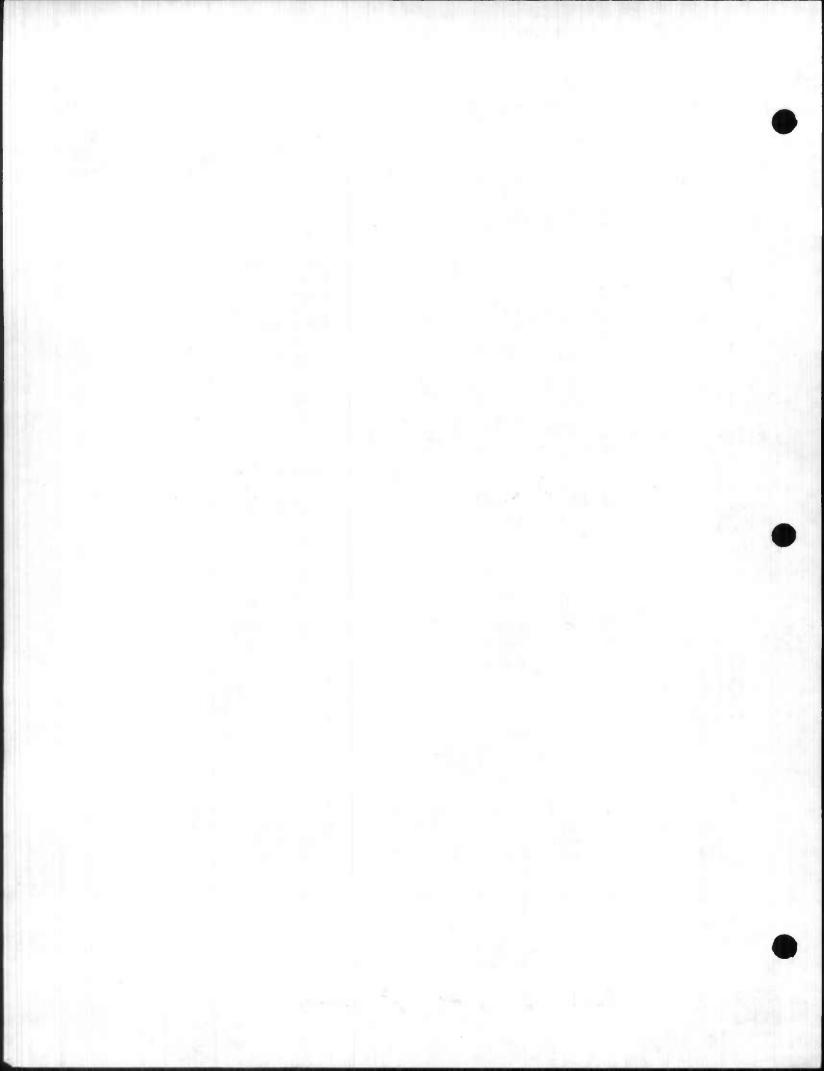
219/2000

State Registrar

DHMH 16 Rev 6/95

M. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

2000 32. Registrer's Signature



State Registrar 31. Date filed (Month, Dey, Year)

See 32. Registrat's Signeture

FEB 1 1 2000

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

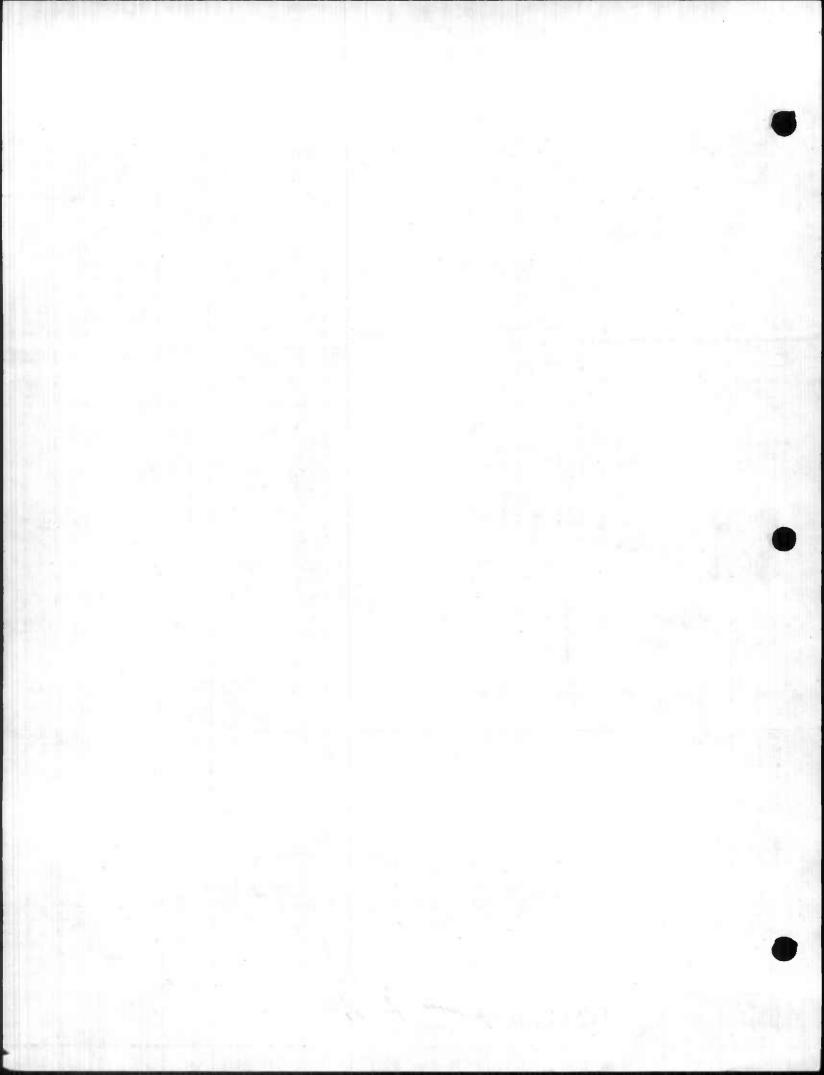
Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

B. Sports

O.C.M.E.

February 07, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lillian Sinth Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Lillian 8:15pm /Medical Vernette 02 05 2000 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Levindale N/H Baltimore If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Hours 10 M 20X Yrs. Director 215-05-9491 12 Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show 1 ☐ Yes XXNo Director MD Baltimore Co. Rosedale 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? r mant be r 21237

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Circle Funeral 5382 King Arthur Neme 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 2 X No 0 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Yeer or Detes: 'natural' Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other ti jury or other traumatic event, the 12th grade 17. Father's Neme (First, Middle, Last) Nursing Private Duty na Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Surname) William Brook Mary Henson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 7410 Hindon Circle Unit # 103, Baltimo Earlene Felton-Daughter Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Metro Crematory Inc.
22. Name end Address of Fecility 2/7/2000 Baltimore, Md 21. Signeture of Furural Service Licensee March F/H West 4300 Wabash Ave, Baltimore Md Jal 21215 23e. Part1. Enfor the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel multiple y pavs sclevosis disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last pue Due to (or es a consequence of): Box 68760, physician Physician/Medical 94 Due to (or as e consequence of): for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 1 Yea 25 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of ceuse of death? page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medicet 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 27, Menner of Deeth 28b. Time of 28c. Injury et Work? 1 S Neturet 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a Hospital Medical 29e. Certifie to certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Vietely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D37573 6,2000 Feb 30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Park Heyhta 119dis MO 7220 Boutine. MD 21708 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Ray 6/95

State

Registrar

2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** MARYJ, VES 04:26AM 2000 02 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MED CTR BATIMORE BALTIMORE H Under 24 Hrs. 8. Dale of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Steta or Foreign
 Country) **Funeral** Days 1 M 227 Months Yrs. 66 Director 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 468 2 No NA MARYLAND Director 10e. Stre et and Number 10f. Zip Code 10g. Citizen of What Country? ò 101 Siaf Nerne 23a 0 d Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Rece - American India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effect.

Department of Health and Mentel Hyglena.

Important: if Item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and any injury or other traumatic avent, the Medical Experimental and the Any injury or other traumatic avent, the Medical Experimental and the Any injury or other traumatic avent, the Medical Experimental Expe Black, Whita, etc. 15 Never Merried 2 Married 3altimore, Maryland 21215-0020 1□ Yes 2₽ No If Yes, Give Year or Dates: Specify Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tuto mobi NA 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) 80 HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 15-41) 19a. Informant's Neme/Reletionship (Type, Print) SAMPSON Niece) 5650 Winchester Bunker JOHANNA 20b. Place of Disposition (Name of cemetery, crematory or other piece, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State Feb altimone RO 4 ☐ Donation 5 ☐ Other (Specify) 10 21. Signature of Funegal Service Licens 22. Name and Address of Fecility HOTNA W. DAL JOWSKI 1005 Dundalk man AVE 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximata Intervel Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** /Medical Immediete Causa (Finel disease or condition resulting in death) UROSEPSIS Examiner Due to (or as a consequence of): Examiner HYPOTHYROIDISM physician and the burial-transit The law requires that the dasth certificats be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as e consequence of) MALNUTRITION Box 68760. Physician/Medical Due to (or as a consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy lindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physicien: 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et tha time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20309 2/9/2000 MD

Registrar

State

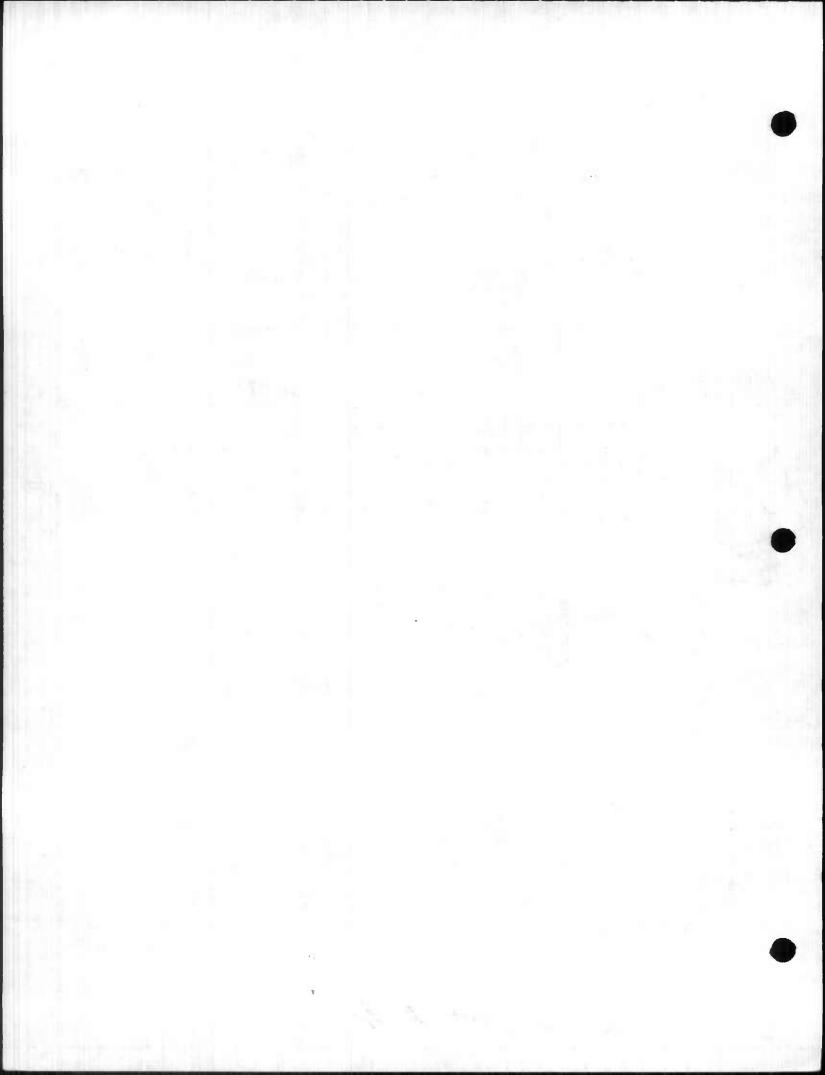
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31. Date filed (Month, Day, Year)

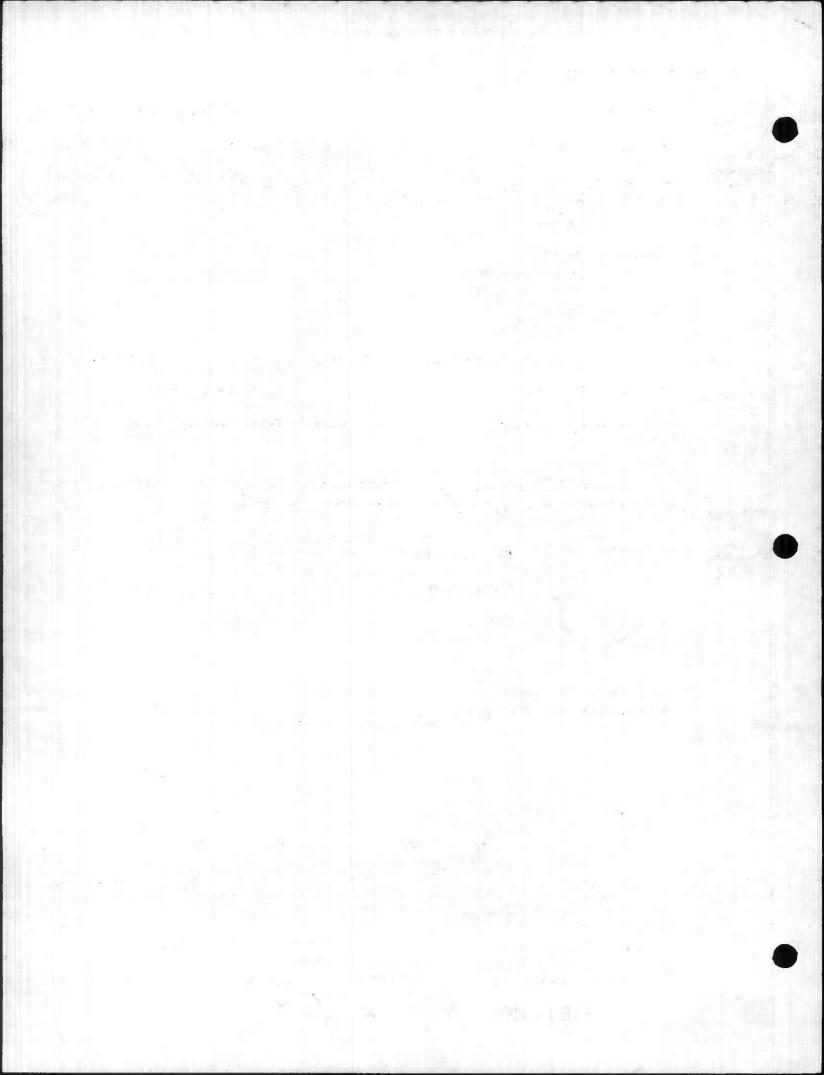
32. Registrar's Signature B. Spacks

30. Name end address of person who completed causa of death (Item 23a) (Type, Print) Audrey Liu

4940 EASTERN AVENUE BALTIMORE, MD 21224



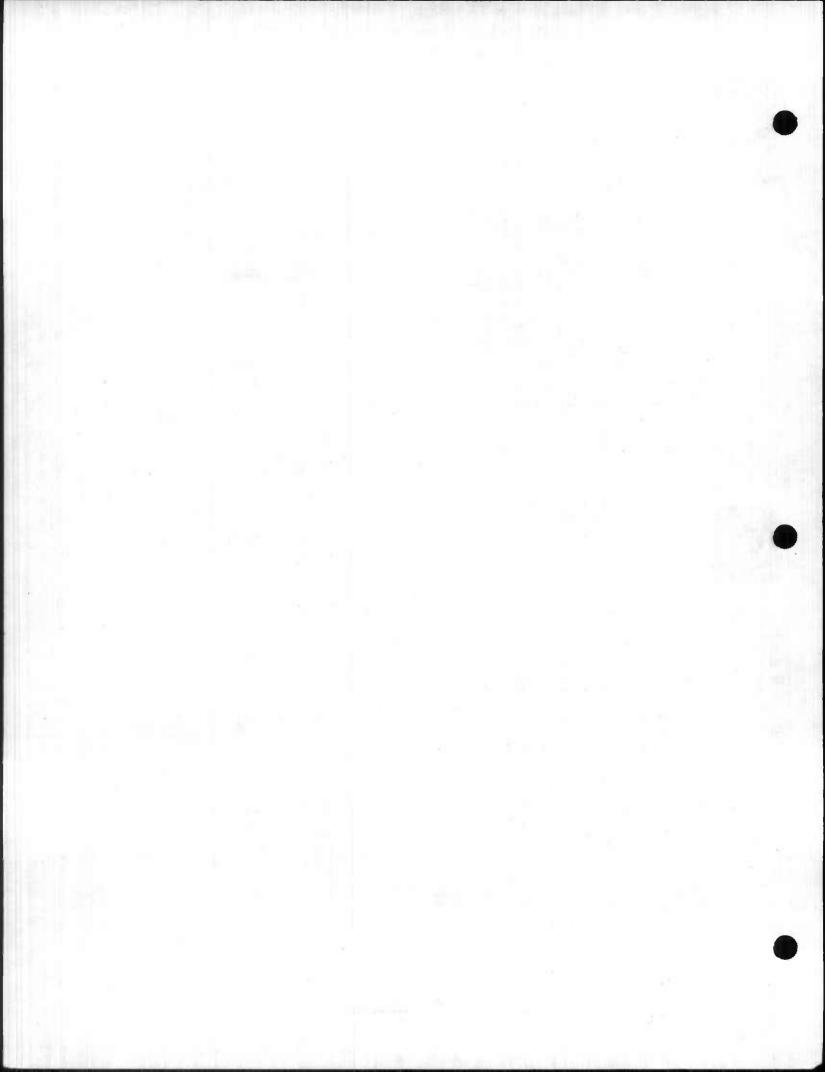
| | Amended I | ter | m#7 perPFHG7 | 80 2/11/20 | 000 EW | | Ce | rtificate | of | Death | | | Reg. No. | | 4. 0 | 00 |
|------------|--|------------------|---|---|---|--|------------------------------|--------------------------------|---------|----------------------------|------------------------|------------------------------|------------------------|--------------------------|------------------------|--|
| | | | 1. Decedent's Name | (First, Middle, La | st) | | | | | | | 2. Date of De Month | eath Day | Year | 3. Tir | ne of Death |
| | Physiciai /Medica | | MARY WI | LHERE | | | | | | | | JANUAR | | | 9:4 | 5 PM |
| | Examine | | 4a Facility Nama (If | not institution, giv | a street and no | mbar) | | | | 4b. City, To | own, or Lo | ocation of Deat | | - | | |
| 4 | | | 9423 Orb | itan Cou | irt | | | | | В | alti | more | | Ba1 | timo | re |
| | Funeral | | 5. Sociel Security Nu | mber 6. S | Sex | 7. Age (In yrs. la | st birthday, | If Undar 1 Months | Yaar | If Under | | 8. Date of Bir (Month, De | rth ev. Year) | | | tete or Foreig |
| L | Director | - | 161-03-1 Usual Residence of D | 026 | I□M 2X)F | 83 63 | Yrs. | Working | Days | 110010 | | Oct 4, | 1916 | | rela | |
| | Maryland | | 10a. State | 10b. County | | 10c. City | , Town or L | ocation | | | | | | | | de City Limits |
| • | 28a-f sho | Į. | MD | Baltin | nore | | Ba1 | timore | | | | | | | 1 🗆 | Yas 2 No |
| | ath with the 23a or 28a unt be not | Funeral Director | 10e. Street and Num 9423 Or | ber bitan Co | ourt | | | 10f. Zip C | | 21234 | | | 10g. Citizen of USA | What Co | untry? | |
| | items 23 | Jer | 11. Marital Status | | 12. Was Dec | cedent Ever In U.S | S. 13. | Was Decede | nt of I | Hispanic Or | igin? (Sp | ecify Yes or No | | ce - Amer | | an, |
| 21215-0020 | urs e | 2 | 1 ☐ Never Marrie 3 🕅 Widowed 4 | | Armed F 1 Yas If Yes, G Year or I | 2∭ No ive | | If Yes, specif | | | | rican, atc.) | Specia | ick, White fy: whi | | |
| 2-0 | natural, | Сощрівте | | 15. Decedent's Ed y only highest gre | | | 16a. Dece | dent's Usuel kind of work | Occu | pation | et of work | ina | 16b. Kind of E | - " | | |
| 21 | within ene. | - De | Elementary/Secon | | | (1-4or 5+) | life. | DO NOT use | retire | d) | st or work | **·y | | | | |
| | or tha | 0 | 12 | | | known | | secreta | ary | | | | | lmini | stra | tion |
| pu | E T SO | 9 | 17. Father's Neme (F | First, Middle, Last, |) | | | | | 18. Moth | er's Nam | e (First, Middle | , Meiden Sume | me) | | |
| yla | | 0 | | L. Lough | | | | | | | | | oughran | | | |
| Maryland | 0 9 9 9 | | 19a. Informant's Nar | | | | 19b. Mail | | | | | | er, City or Town | | | , |
| | and alth a 27 | | Kathleen | | ughter | aat Di | and Diam | | | itan | Cour | | imore, | | 2123 | |
| Baltimore, | Pages hart of H int: If he iny or of | | | osition Cremation 3 Other (Specil | | Ce | metery, cre | osition (Neme metory or oth | er ple | ece) | | Date | 20c. Location | - City or | IOWN, Sta | 110 |
| Balt | permit. Pa Department (groonfant) any injury once. | | 21. Signature of Fun | eral Service Licer Seph B. | Van Sa | nty + | | | | | | | . Baltin | nore | Stre | et |
| × | de | 1 | 3a, Part1. Enter the | disease, or com | plications that | caused the death | | altimo | | | 2120 cerdiac | | arrest. | 1 | Appro | ximate |
| | Physician | | shock, or heart | failure. List only | one ceuse on | each line. | | | , | | | | | į | Interva | al Between and Death |
|) | /Medical | | Immediate Cause (F | inal | Re | ESPIRATOR | PAI F | 21110 | - | | | | | 1 | | |
| | Lxaminer | | disaasa or condition resulting in death) | | a | | • | | | | | | | | | |
| | | 1 | | | PN | EUMONIA | as a conse | quence or): | | | | | | | | |
| | physician end s the burial-transit | Examiner | Sequentially list con- | ditions | b | | as a conse | quence of): | | | | | | 1 | | |
| ó | an en rial-tr | Ĭ | Sequentially list conditions, leading to immoceuse. Enter Underlicause (Disease or In | nediate lying | Co | PD | | , | | | | | | | | |
| 68760, | yslcie | 0 | Cause (Disease or Ir that initiated events resulting in death) La | | C | • | as a conse | guence of): | | | | | | | | |
| | ing e a a | Σ | resuming in death) La | | d. As | THMA | | | | | | | | 1 | | |
| Box | iras that the death signed by the atterd be detached for u | rnysician | Part II. Other signific | ant conditions o | contribution to | teath but not resu | Iting in the I | inderlying cei | ise ni | iven in Part | 1 | 23b. Did | tobacco use c | ontribute | to the ca | use of death |
| P.0 | ed by the | n ya | | | - | DEMENT | - | andonying oo | 9 | | | | Yes 2 No | | | 4 Unkno |
| | | | | -1.01 | , | DEMENT | LA | | - | | | | | | | |
| Records, | v requires been sign should be | Completed by | | | | A | | | | | | 24a. Wes | s en autopsy ormed? | | available | opsy findings prior to in of cause |
| Re | The law ate has b page 2 s | | | | | | | | | | | 10 | Yes 20 No | | Yes | 2□ No |
| a | certificate rector, page | | 25. Was cese referre | nd to madical | | | | | | 00 Di- | (D | | | | 1 🗆 103 | 2010 |
| of Vital | | | examiner? | | Hospital: | Hanatiant ODS | TR/O to object | all pos | Ot | har | | th (Check only ome 5 MRes | | har /Can | nife et | |
| of | 8 2 3 | - - | 27. Menner of Deeth | 10 | | | ER/Outpatie 28b. Time o | | c. Inju | | ursing Ho | | how injury occu | ther (Special arred | cny) | |
| on | ding Ph. After thi funaral | 2 | 1 ☑ Neturel 2 ☐ Accident | 5 Pending investigatio | | of Injury oth, Dey Year) | NA | м | | ork?]Yes 2∐ | No | | 14- | | | |
| Division | Attending ir death. ector: After by the fune | Cermication: | 3 Suicide | 6 Could not b | | | | raet, factory. | | | | 28f. Location | (Street end Num | ber or Ru | iral Route | Number, |
| 5 | aftar Direction of in by | | 4 Homicide | determined | build | e of Injury - At hor ling, etc. (Specify) |) | NA | | | | | Wn, State) | | | |
| ٦ | Hospi 24 hou Funer tely fil | enical | 29a. Certifier (Check only one) | Certifying Ph | niner: On the I | e best of my know basis of examinati | /ledge, deal on and/or in | th occurred at | the ti | ime, date a opinion, de | nd place, ath occur | and due to the | cause(s) and n | nanner as , and due | steted. | use(s) |
| | within 2 To the comple | | 29b. Signature and ti | itle of certifier | and mai | nner stated. | | 290 | Licen | se number | | | 29d. Dete sign | ed (Mont | h. Dav. Y | ear) |
| | ₩ ¥ ¥ 8 | | De Aue | mas RAR | an | | | | | 010 | | | 1/31/ | | , - - -y, ' | |
| | | | 30. Name and address | ss of person who | completed cau | ise of deeth (Item | | Print) | RA | BA | 171 | yors, | ЧР | 2/2 | 34 | |
| | State | , | 31. Date filed (Month | | | Registrar's Signat | | 4 | - | | | , , | | | | |
| | Registra | | | FEB 1 | 1 2000 | Den | ww | 13 | 1 | park | 2) | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

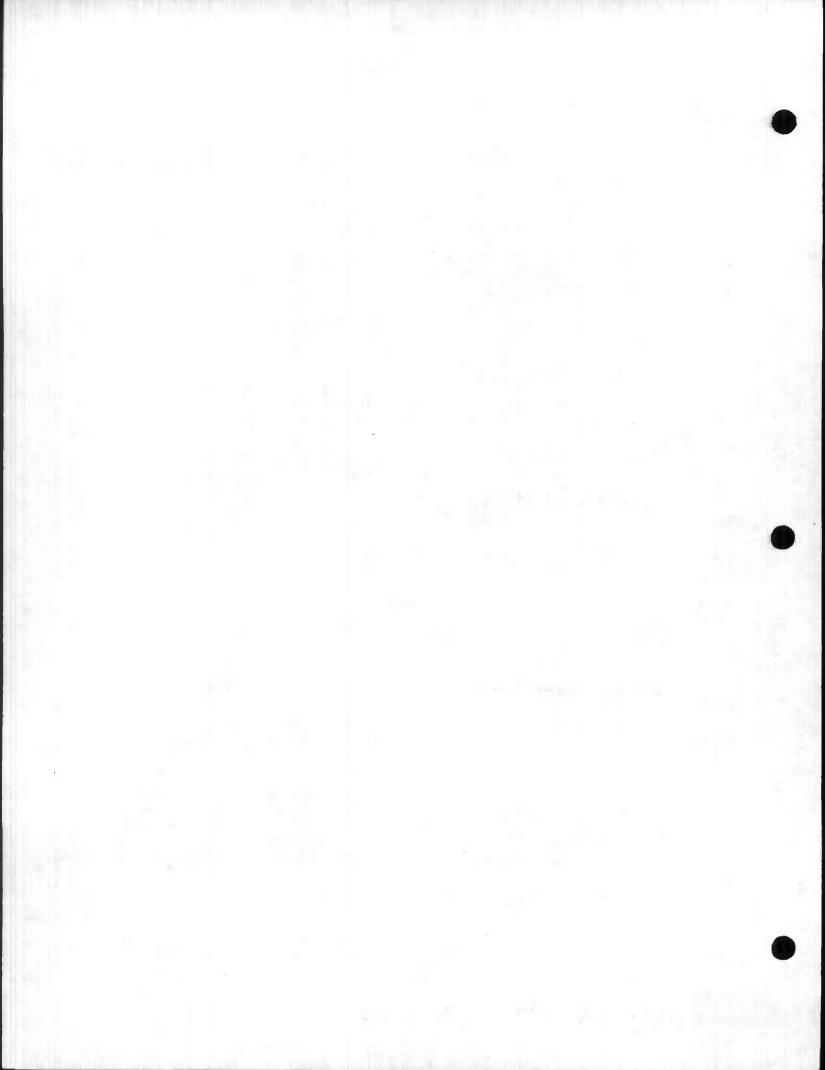
| | | | | C | ertificate of | f Death | | Re | g. No. | U | 14301 |
|---------------------|--|--|---|-----------------------------|--|------------------|-------------------------------|---|-----------------|------------------------------------|---|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | | Pate of Death | | Year | 3. Time of Death |
| | Physician /Medica | SODILLOILLA | B. Whe | atley | | | | bruary | Day 6 | 2000 | 18:30 |
| | Examine | A. C. No. Alexander Adv. At an at an at | e street and number) | | | 4b. City, To | wn, or Locatio | n of Death | 4c. County | of Death | |
| | | Union Memorial | Hospital | | | | cimore | | NA | 1 | |
| | Funeral Director | 212 01 0224 | | yrs. last birthda 3 Yrs. | Months Day | | Min. 8. D | Pate of Birth Month, Day, 1 - 14- | Years 7 | 9. Birthp Coun | Nace (State or Foreign http) MD |
| | Du a | Usual Residence of Decedent 10a. State 10b. County | 100 | . City, Town or | ocation | | | | | 1 | 0d. Inside City Limits |
| | denyth of the | | 100 | altimo | | | | | | | 1 Yes 2 No |
| | vith the Me t or 28e-4 e | 10e. Street and Number | | altimo | 101. Zip Code | | | 10 | g. Citizen of V | What Coun | Λ. |
| | oth with the Merylen 123s or 28s-f show that he notified at | 2647 Aisquith | | | 21218 | 3 | | | USA | 1 | |
| Maryland 21215-0020 | 72 hours efter deeth with the Meryland natural, or hams 23s or 28s-f show deal Examiner must be notified at well by Figures i Director | 3 Widowed 4 □ Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | in U,S. 13 | Was Decedent of If Yes, specify Cu 1 Yes 2 N | | | Yes or No- n, etc.) | Blac | e - Americ sk, White, r: Bla | etc. |
| 5-0 | natural', | 15. Decedent's Ed (Specify only highest gra | ducation | 16a. Dec | edent's Usual Occ | upation | at of working | 1 | 6b. Kind of Bu | usiness/Inc | Justry |
| 21 | ed within 72 hor yglene. er than "natura ft, the tid | Elementary/Secondary (0-12) | College (1-4or 5+) | | e kind of work don DO NOT use reti | red) | | | | | 1 - 1 |
| 12 | | | NA | סמ | mestic | 140.00.00 | | | | - | ople home |
| anc | 25.5 | 17. Father's Name (First, Middle, Last, Nathaniel | Perry | | | | er's Name <i>(Fin</i> llie | st, Middle, M | | anle | 277 |
| Ž | should in marked umarked | 19a. Informant's Name/Relationship (| | 405-145 | iling Address (Stre | | | 4. N b c | | | 21206 |
| Ma | 01 | | evenson | |)8 Mora | | | | | | C009) |
| 0 | f Heelth from 27 other tr | 20a. Method of Disposition | | b. Place of Dis | position (Name of | | De De | | Oc. Location - | | |
| Baltimore, | H H H | 10 Burial 2 ☐ Cremation 3 ☐ | | | ematory or other p | | - 102 | 12 20 |)00 n= | | llstown,M |
| 量 | Pura Pura Pura Pura Pura Pura Pura Pura | 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer | | | Mem. Pr | | | | | | nd 21202 |
| Ba | permit. Peges to Department of Himportant: If he any Injury or ot since. | Jun Ch | Tin II | | M.C.Mar | | | | | - | |
| | | 23a Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the | | | | | | | 1 | Approximate Interval Between |
| 1 | Physician | arous, or front lander. Est only | Cito Calobo Cit Gap 1 Mile. | | | | | | | | Onset and Death |
| | /Medical | Immediate Cause (Final disease or condition | (| SEPT | IC SHO | ac K | | | | | 24 hours |
| П | Examiner | resulting in death) | a. Due | to (or as a cons | | CI | | | E Be | | 24 hours One Week |
| - | Z = - | | , PNEL | MONI | 4 | | | | | | One Week |
| | physician and the buriel-transit | Sequentially list conditions, | Due | lo (or as e cons | equence of): | | | | | | |
| 68760, | | | c | | | | | | | | |
| 387 | ficete be physicia the bu | resulting in death) Last | Due | o (or as a cons | equence of): | | | | | į | |
| | certification of the second of | | d | | | | | | | 1 | |
| Box | deeth ce ettendii od for use | | | | | | | | | 40.00 | |
| P.0. | \$ 55 × | Part II. Other significant conditions of | | Carrier - 100 | | 1 | . 1 | 4 🗆 V- | | 3 Pro | the cause of death? |
| | thet deb | Atrial tibrila | tion (| hroni | c Obstructisease | tive P | ulmmany | 10 10 | s 2□No | 3 Pro | MICH 45 CHICHONI |
| Vital Records, | een sign hould be | | | D | isease | | | | | 24b. W | ere autopsy findings |
| 00 | on one | Diabetes, C | oronary a | rkry | disease | -1 | | perform | 1907 | co | ailable prior to mpletion of cause death? |
| Re | certificate has been si irector, page 2 should Be Completed | Consider | 101 | 77 | | | | 1 🗆 Yes | s 2)2 No | | Yes 2 No |
| tal | ertificat potor, p | 25. Was case referred to medical | irt failur | 2 | | 26 Place | e of Death (Ch | | • | | 3.03 24.10 |
| <u>></u> | Physicien: this certificate, and director, To Be | examiner? | Hospital: 1 Inpatient | 2 ∏ ER/Outpati | ent 3 DOA | Wher | ursing Home | | | er (Specif | (v) |
| o | erthis seral di | | 28a. Date of Injury (Month, Day Yes | 28b. Time | of 28c. In | jury at lork? | | | w injury occur | | |
| Division | of Attending of the death. Director: After in by the funeral in t | 1 Natural 5 Pending 2 Accident investigation | | (r) Injury | | Yes 2 | No | | | | |
| <u> </u> | Afte pr de by th | 3 Suicide 6 Could not be determined | 28e. Place of Injury - | At home, farm, s | treet, factory, offic | 9 | | ocation (Str. | | per or Rura | al Route Number, |
| ٥ | tal or Attending P is effer death. el Diractor: After tel ind in by the funerication: | | bulling, old. [c) | -cuiy) | | | | | | | |
| | To the Hospital or Attending Physicien: The is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com | 29a. Certifier 1 Certifying Ph | ysician: To the best of my niner: On the basis of exar | | | | | | | | |
| | the F thin 24 mplet | | and manner stated. | | | | | | | | |
| | 0 1 0 N | 29b. Signature and title of certifier | 111. | | | nse number | 700111 | | d. Date signe | S. Hina | |
| | 1 | 1. Was | 11 MD | | A | 124 | 38946 | 2 | 02-0 | 16-2 | ,000 |
| 1 | 1 | 30. Name and address of person who | | | | | | | | | |
| 1 | 1./ | | NION MEMORIA | | | 1 EAST | TUNIVE | RSITY | PARKWA | Y, BA | LTIMORE |
| | State Registrar | 31. Date filed (Month, Day, Year) FEB 1 1 2000 | 32. Registrar's S | | pouls | | | • | | | |
| | | 1 50 50 50 50 | / | | | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

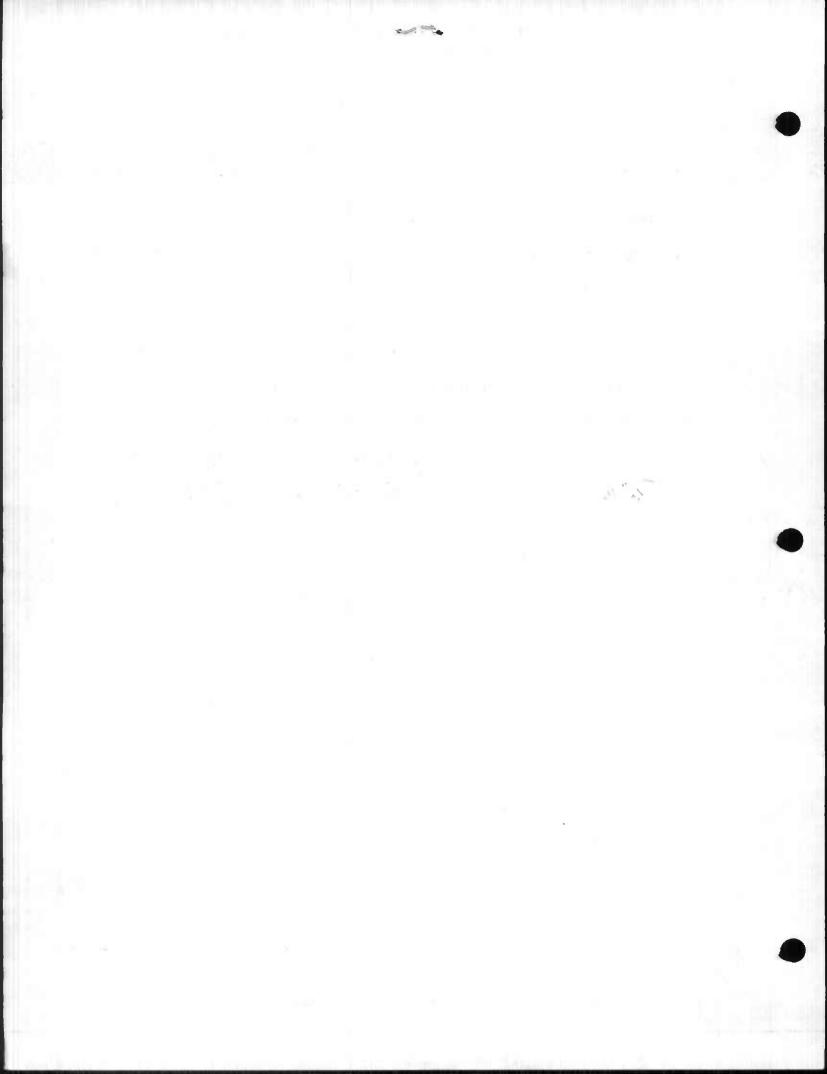
| | 1. Decedent's Nem | IN (FITS), MICCIN, LE | 151) | | | | | | 2. Date of De | ath | | 3. Time of Deatl |
|--|--|--|--|---|---|--|--|---|---|---|---|---|
| hysician | The second second | RGARET | , | WODE | | | | | Month | Day | Year | 8:30 A |
| /Medical Examiner | 4a Facility Name (I | | | | | | | 4b. City, Town, or | | | | 0. 30 7 |
| zxaminer | | Westland | | | | | | Arbutu | s | Balti | | |
| uneral | 5. Sociel Security N | | | Age (In yrs. | last birthda | 7/ | er 1 Year | If Under 24 Hrs | | th . | 9. Birthp | lace (State or Fore |
| rector | 217-38- Usuel Residence of | 2298 | 1□M 2⊠F | 89 | Yrs. | Months | Days | Hours Min. | March | 25,1910 | III | laca (State or Fore try) inois |
| N N | 10a. State | 10b. County | | 10c. Cit | ly, Town or | Location | | | | | 1 | 0d. Inside City Lin |
| ms 23s or 28s-f show Linux be notified at heral Director | Maryland | Baltimo | re | Ar | butus | S | | | | | | 1 ☐ Yes 2 🖾 |
| or 28a-f a be notified Directo | 10e. Street and Nur | mber | | | | 10f. Z | ip Code | | | 10g. Citizen of W | /hat Coun | try? |
| and be | 500 | 03 Westla | nd Blvd. | Apt. | F | | 2122 | 7 | | United | l Sta | tes |
| Examine by Fur | 3 D Widowed | ied 2 Married | 12. Wes Decede Armed Force 1 Yes 2 If Yea, Give Year or Dete | es? ⊠ No | ,S. 1 | | | lispanic Origin? (S an, Mexican, Puer Specify: | pecify Yes or No to Rican, etc.) | Black | - Americ k, White, White | etc. |
| At the Medical Completed | (Page | 15. Decedent's Ed | | | 16a. De | cedent's Us | ual Occup | pation | dina | 16b. Kind of Bu | siness/Ind | Justry |
| and old | Elementery/Seco | ondary (0-12) | College (1-4 | or 5+) | life | . DO NOT | use retire | during most of wo d) | rking | | ** | |
| Co that | 8 | | | | Home | emaker | | | | Ov | vn Ho | me |
| Be Se | 17. Father'a Name | (First, Middle, Last) |) | | | | | | | , Maiden Sumam | e) | |
| To wile | Alwin W | | | | | | | | E. Bello | | | |
| n al | | eme/Reletionship (| | | | | | and Number or Re | | | | |
| 9 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | Eda Gree | k (Sister | c) | 20h E | | 03 Wes | | d Blvd. | Apt. F A | 20c. Location - | | |
| ant: If its ury or of | 1⊠ Buriel 2 | Cremetion 3 5 5 Other (Specif | | ato C | cemetery, c | rematory or 1 Ceme | other ple | | 2/9/00 | | • | |
| any in | 21. Signeture of Fu | meral Service Licer | insee | ۸.,, | 0 | | | ess of Facility Am hur Spri | | neral Ho | | |
| | 23a, Part1. Enter the | he disease, or com ort feilure. List only | plicetions that cau | sed the deat | Do not | | | | | | , 1115 | Approximeta |
| sician | SHOOK, OF HEE | intreliure. List only | | | 7 | | | | | | 1 | Interval Between Onset and Deatl |
| edical | Immediate Cause (| (Finel | | Ł. | 11- | 1 1 | | | | | | |
| | disease or conditio | on | (m)21 | notive | HEG | 1 Ha | Tine | 4 | | | - | Hears |
| miner | disease or condition reaulting in deeth) | n . | a. Congl | Due to (c | HCGr or as a cons | sequence of | ituse | 4 | | | 1 | years |
| | disease or conditio | on . | . Conge | Due to (c | HCG or as a cons | sequence of | iture | 1 | | | | years |
| a liner | disease or condition reaulting in deeth) | on | b. Hey | Due to (c | HCGO or as a cons or as a cons | sequence of | iluse):): | 4 | | | | years |
| and I-transit Xaminer | disease or condition resulting in deeth) Sequentially list conif any, leeding to incluse. Enter Under Cause (Disease or Cause (Disease (D | enditions, and a state of the s | b. Hey | Due to (c | HCG or as a cons or as a cons | sequence of | ituse):): | • | | | 8 1 8 1 | years |
| and I-transit Xaminer | disease or conditio | enditions, nmediate orlying Injury | b. Hey | Due to (d | or es a cons | sequence of |): | , | | | | years |
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| at Director: After this certificate has been signed by the attending physician and sed in by the funeral director; page 2 should be detected for use as the burish-transit Certification: To Be Completed by Physician/Medical Examiner | disease or condition resulting in deeth) Sequentially list confit any, leading to improve the cause. Enter Under Cause (Disease or that initialed events resulting in deeth) I | inditions, inmediate shying linjury stast ast investigation for the determined investigation of the determined investigation o | d | Due to (of | PER/Outpate 28b. Time trijun | equence of | cause given the control of the contr | 26. Place of Dener: 4 Nursing Hry at rk? Yes 2 No | 24a. Wes perfet 1 = 24b. Check only thome 5 A Resident City or To | Yes 2 No an autopsy ormed? Yes 2 No one) idence 6 Othe how injury occurr (Street and Number win, Stete) | 3 Prol 24b, We eve co of 1 [ar (Specif) red oner as si | the cause of debebly 4 Unkosere autopsy findinaliable prior to impletion of cause death? Yes 25 No 1/ Route Number, |
| The Funnish Direction: After this certificate has been signed by the attenting physician and pleately tilled in by the funeral director, page 2 should be detected for use as the burish-transit edical Certification: To Be Completed by Physician/Medical Examiner | disease or condition resulting in deeth) Sequentielly list confidency list co | red to medical No h S Pending investigetion 6 Could not b determined | d | Due to (of | PER/Outpate 28b. Time trijun | equence of | cause gives 28c. Injury World of the time, in my control of the time, in my control of the time. | 26. Place of Dener: 4 Nursing Hry at rk? Yes 2 No | 24a. Wes perfet 1 = 24b. Check only thome 5 A Resident City or To | Yes 2 No an autopsy ormed? Yes 2 No one) idence 6 Othe how injury occurr (Street and Number win, Stete) | 3 Prol 24b. We eve coc of 1 [er (Specif) erd er or Rura nner as sland due to | the cause of debebly 4 Clinkusere autopsy findinaliable prior to impletion of cause death? Yes 25 No Will Route Number, its lated. |
| The Function of the first certificate has been signed by the attenting physician and pleately tilled in by the functal director, page 2 should be detached for use as the burial-transit edical Certification: To Be Completed by Physician/Medical Examiner | disease or condition resulting in deeth) Sequentielly list confidency list confidency leading to improve the cause. Enter Under Cause (Disease or that initiated events resulting in deeth) It. Pert II. Other algniff Pert II. Other algniff 25. Was case refer axaminer? 1 Yes 2 27. Manner of Deett 1 Xerident 3 Suicide 4 Homicide | red to medical No h S Pending investigation Could not be determined PCertifying Ph 2 Medical Examititle of certifier PCERTIFIER PC | Hospitel: 1 Inp 28a. Date of I (Month, a) 28e. Plece of building, yelclan: To the beniner: On the basis and manner | Due to (of | PER/Outpate 28b. Time trijun | equence of | cause gives 28c. Injury. office det the time, in my c | 26. Place of Dener: 4 Nursing Hark? Yes 2 No | 24a. Wes perfet 1 = 24b. Check only thome 5 A Resident City or To | Yes 2 No an autopsy ormed? Yes 2 No one) idence 6 Othe how injury occurr (Street and Number win, State) cause(s) end madate and place, a | 3 Prol 24b. We eve co of i 1 [1 [er (Specif) red one as stand due to 1 (Month, | bebly 4 Unkers autopsy findin allable prior to impletion of cause death? Yes 2 No What Route Number, italed. Italed. Day, Year) |
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State of Maryland / Department of Health and Mental Hygiene 0 0 4 3 0 3

| | | | | | Certif | ficate o | f Death | 7 | Re | g. No. | | 7000 |
|---|----------------|---|----------------------------------|---|-------------------|--------------------------------|------------------------------------|----------------------|---|------------------|-----------------------------|--|
| | | 1. Decedent's Neme (First, Middla | , Last) | | | | | | 2. Dete of Deeth | 1 | | 3. Time of Death |
| Physic | | CALVIN | | | | WEI | SSNE | R | Month | Dey | Yeer 2000 | 15:10 |
| /Med | | 4a. Fecility Neme (If not institution, | give street and number | 1 | | | | | ocation of Death | 4c. County | | 13,10 |
| Exami | ner | 1.12 | | | | | | | | | | 40.4414 |
| | | GOOD SAMARIT | | | table to 1 B | If Undar 1 Ye | IS /7 L | 11M6 | RE | PALITA | ORE | MARYLAND |
| Funeral Director | | 5. Social Sacurity Number 216-18-4981 | 6. Sex. 7. Ag | ge (In yrs. last bi | | Months De | s Hours | Min. | 8. Data of Birth (Month, Day, Feb. 22 | Year) 1925 | 9. Birthpi Count Mary | ieca (State or Foreign try) yland |
| B | | Usuei Rasidenca of Decedent | | | | | | | | , | ,,,,,, | , |
| /lan | | 10e. Stete 10b. County | | 10c. City, Tov | wn or Locati | ion | | | | | 10 | 0d. Inside City Limits |
| Man | ō | Maryland N/A | | R: | altimo | oro | | | | | | 1X□ Yes 2□ No |
| the 28s | Director | 10e. Street end Number | | D(| | 10f. Zip Code | | | 10 | og. Citizen of V | What Cours | da C |
| E 8 | | | | | | 101. Zip 0001 | | 1014 | 10 | | | |
| ath 23 | 60 | 3211 Southern A | | | | | | 1214 | | | | tates |
| UCCU burs after death with the Marylan rat, or Hems 23a or 28a-f show Examiner must be nortified at | Funeral | 11. Meritei Stetus | 12. Wes Decedant Armed Forces | Ever in U,S. | 13. Was | s Decedant of es, specify C | of Hispanic Or uben, Mexica | rigin? (Span, Puarto | ecify Yes or No- Rican, atc.) | | a - America k. Whita, e | |
| aft of | I | 1 Never Merried 2 XMarrie | ed 1X Yes 2 I | | | Yas 2 🗆 | | | | Specify | | |
| 72 hours after death with the Maryland 7atural", or flems 23a or 28s-f show folded Examer must be notified as | b | 3 Widowed 4 Divorced | Yaer or Dates: | WWII | | Tuo Ling | io opaony | | | Specily | WII | ite |
| d within 72 hours aff giene. If then "natural", or | Completed | 15. Decedent' (Specify only highest | s Education | 168 | Decedent | t's Usuel Occ | cupetion ne during moi ired) | nt of work | ina 1 | 16b. Kind of Bu | siness/Ind | lustry |
| within ene. than | Pe | Elementary/Secondery (0-12) | College (1-4or | 54) | life. DO | NOT use rat | ired) | SI OF WORK | ing | | | |
| d wit | 0 | 12 | Conogo (1 401 | | Steel | Worke | r | | | Steel | Pro | duction |
| | BeC | 17. Fether's Neme (First, Middle, L | ast) | | * | | 18. Moth | er's Neme | e (First, Middle, M | laidan Sumam | 10) | |
| ind yidling ZIZI. Id 2 should be filed within ' Ith and Mental Hygiene. It is marked other than ' Traumatic event, the way | 0 | Not Known | Not | Known | | | U41 | da l | Hauck | | | |
| d Me | 10 | Not Known 19a. Informent's Neme/Rejetiohsh | | | h Mallina A | Address (Otro | | | | 02 | 0 | 0.41 |
| d 2 should th and Mer 7 is marks traumatic | | | | | | | | | al Route Number, | | | |
| | | Steven A. Weiss | ner / Son | - | | | le Ave | nue | Baltim | | _ | |
| or of | | 20e. Method of Disposition 1X Buriei 2 ☐ Cremetion | 3 Removel from State | | ary, cremato | on (Name of ory or other p | olaca) | i | Dete 2 | 20c. Location - | City or To | wn, Stete |
| emit. Pages 1 ar Department of Hea moortant: if item 3 iny injury or other inge. | | 4 Donetion 5 Other (Sp | ecity) | | ood Ce | emeter | V | 2 | /14/2000 | Parkvi | 11e. | Maryland |
| permit. Pages 'Department of Himportant: if ite any injury or of once. | | 21. Signature of Funeral Service L | icersae Timoth | v Harmar | 22. No | eme end Add | dress of Fecil | ity | | | , | |
| | | > Tulothus | thur | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | nard J 5 Harf | . Ruck | , In | c. Funer Baltimor | al Home | 21214 | |
| _ | | 23a. Part1. Entar the disaesa, or t shock, or heert failure. List of | complications that cause | d tha deeth. Do | | | | | | | 1217 | Approximete |
| Ohuslalan | | shock, or heart faffure. List of | only ona causa on each li | ine. | | | , | | | | | Interval Batween Onsat and Death |
| Physician /Medical | | Immediata Causa (Finel | | | | | | | | | | |
| Examiner | ш | diseesa or condition resulting in death) | a. MYOC | ARDIAL | INF | ARCT | IDN | | | | | |
| | | Toothing it dadding | | Due to (or es e | | | | | | | I | |
| D # | i e | | - L CORONI | ARY AR | TERY | 015 | EASE | | | | 1 | |
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| an an al | | if any, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or injury | C. CHRONIC | ORCTAL | 11. | 1 01-1 | 100.000 | | | | i | |
| certificate be executed ording physician end use as the burial-transit | edical | thet initiated events | C. CAKENIC | Due to (or es e | consequen | nce of): | MU N JFK | T PI | SEASE | | - | |
| tifica ng ph as th | P | rasulting in deeth) Lest | | , | | | | | | | į | |
| | 3 | | a. PERICHI | ERAL V. | ASCUL | LAR |) I S EAS | E | | | | |
| eath cer ettendir for use | ciar | | | | | | | | | | | |
| requires that the death | Physician | Pert il. Other significant condition | ns contributing to death b | out not resulting | in tha unda | rlying cause | given in Pert | i. | 23b. Did tol | bacco use cor | ntribute to | the cause of death? |
| that the ed by detac | Ph | | | | | | | | 1)X Ye | s 2 No | 3 Prob | bably 4 Unknown |
| es tha | by | | | | | | | | | | - | |
| Physician: The lew require this certificate has been sired ral director, page 2 should it | Pe | | | | | | | | 24a. Was an | | | ara autopsy findings eliable prior to |
| iew requias been a 2 shoul | Completed | | | | | | | | perion | 1601 | cor | mpletion of cause |
| The levelete has page 2 | E | | | | | | | | | attend | 1010 | |
| ifficete for, pa | | | | | | | | | 1 □ Ye | • | 1 | Yes 2 No |
| Physician: The this certificete | Be | 25. Was case raferred to medical exeminer? | Hospital: 3.4 | | | | | e of Deatl | (Check only one | a) | | |
| Physi this c | 2 | 1 Yes 2 No | Hospital: 1 Inpatie | ent 2 ER/O | utpetient | 3LI DOA | | | me 5 Resida | | | 1) |
| aling P. After t | Certification: | 27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending | 28a. Dete of Inju (Month, Da | | Time of Injury | 28c. In | jury et vork? | | 28d. Describe ho | w injury occur | red | |
| or Attending effer death. Director: After d in by the fune | at | 2 ☐ Accident investige | etion | | | M 1 | ☐ Yes 2 ☐ | No | | | | |
| offer death effer death Director: | 1 | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide detarmin | ned 288. Place of In | ury - At home, fa | arm, street, | , fectory, offic | >e | | 28f. Location (Str. City or Town, | aet and Numb | er or Rura | l Route Number, |
| d in d | je l | 4 D Homidae | ounding, at | c. (Specify) | | | | | City of Youri, | , State) | | |
| Hospital 24 hours Funeral I | | 29a. Certifier 1 Certifying | Physician: To the best | of my knowledo | a. deeth oc | curred at the | tima deta a | nd piaca | and due to the ce | usa(s) and me | nner as st | eted |
| To the Hospital or Attending F within 24 hours eiter death. To the Funeral Director: After completely filled in by the funer | edical | (Check only 2 Medical E | xaminar: On the basis o | f examination er | nd/or Invest | tigetion, in m | y opinion, de | eth occurr | ed at the time, da | te end place, | end due to | the cause(s) |
| To the I within 2 To the | ĕ Z | 29b. Signeture and title of cartifier | GIV MOUNDS | | | 29c Line | nse number | | 20 | d. Dete signed | /Month | Day Year) |
| F * F 8 | 100 | | | | | | | | | | | |
| A | | Kon Koren | MD | | | RES | -P 13 | 458 | F | EBRUA | RY 10 | 1 2000 |
| // | | 30. Name and address of person w | | | | nt) | | | | | | |
| | | RON S. ROSEN | 1 5601 6 | LOCH RA | FVEN | Bonks | VARD | BI | ALTIMORE. | MARYL | AND | 21239-2995 |
| St | ate | 31. Date filed (Month, Day, Year) | 1 2000 32. Ragisty | ar's Signature | 4 | 1 | n. V. 1 | | | | | |
| Regist | - | FERT | T 7000 PY | Jeper | | 100 | vers! | | | | | |

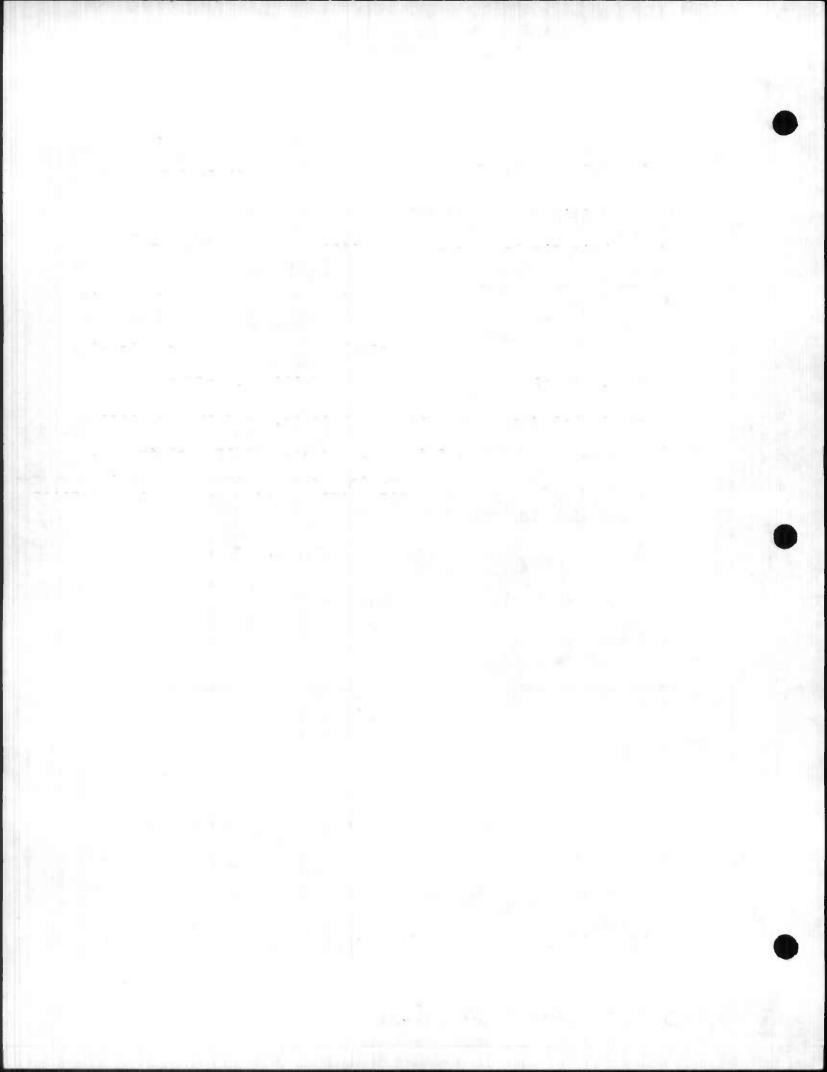


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KMA EBRUAR DAM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) B. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 M F 79 Yrs. 219-18-8707 Director 28 1920 **Usual Residence of Decedent** the Marvierd 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow r 28e-f show 1 Yes 2 No Baltimore Md Dundalk Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 2908 Dunbrin Circle 21222 USA Apt D Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried altimore. Marviand 21215-0020 1 Yes 2 No Specify: ò Specify: White 3 ■ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiana. Dry Cleaning Clerk permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygian Important: if Item 27 is marked other th any Injury or other traumatic avant, the 6 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Sallie F. Hoffman Edward W. Manuel To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Md 21222 2908 Dunbrin Ct. Edward Wineholt/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 Cremation 3 Removal from State 02 12 Belair Mem. Gardens Belair, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Road, Balto, Md 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner slotan and burial-transit The law requires that the death cartificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician as the burial P.O. Box 68760. Physician/Medical Due to (or as a consequence of) USB 88 been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the causs of death? 3 Probably 4 Unknown 1 Yss 2 No Division of Vital Records. þ 24b. Wera autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 e 2 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funaral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ↑ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury st Work? Aftar 5 Pending investigation 1 Natural 1 | Yes 2 | No 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Yd of belili 4 Homicide Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie pletely (Check only one) within 2 To the I the th 29d. Date signed (Month, Day, Year) 29c. License number and address of person who completed cause of death (Item 23a) (Type, MI 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 1 **DHMH 16 Rev 6/95**

414



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 04305 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month WALL **Physician** () LIVE 2000 1042 PM ' /Medical 4b, City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner SACTIMORE ERCY HOSPITAL N/A If Under 24 Hrs. if Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) **Funeral** Days Hours 1 M 2 KF Months 214-22-4626 73 Director 02 01 1927 MD Usual Rasidanca of Dacedant the Maryland 10c. City. Town or Location 10d. Insida City Limits 10a Stata 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nas 2 No Director Md N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 31 N. Belnord Avenue 21224 USA 2 should be filed within 72 hours efter death on and Mentel Hygiene.

Is marked other than "natural", or items 23. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 █ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Biack, Whita, atc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify à 3 Widowed 4 Divorcad White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/industry 15. Decedent's Education (Spacify only highast grada complated) Elamantary/Secondery (0-12) Collega (1-4or 5+) Housewife Own Home 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Henry Schrieber Clara Pinkus 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informent's Name/Reletionship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: If frem 27 is n any injury or other traum John Wall, Sr. /Husband 31 N. Belnord Avenue, Balto, Md. 21224 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 Donetion 5 Othar (Specify) Oaklawn Cemetery 0211 Baltimore, Md. 22. Nama and Addrass of Facility Moran-Ashton-Dabrowski Funeral Home, Inc 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List cm/h one cause on each line. Baltimore Street, Balto, Md21224 Approximata Intarval Batween Onset and Daath **Physiclan** immediata Causa (Final disaese or condition resulting in deeth) /Medical 0945 Examiner Examin signed by the attending physiclen and defeated for use as the buriel-transit Sequantially list conditions, if any, laading to immadieta causa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avants Dua to (or as a consaguanca of) Box 68760 certificate be Physician/Medical Dua to (or as a consaquance of): rasulting in daath) Last 88 P.O. 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 No 3 Probably Winknown Records, þ 24b. Were eutopsy findings available prior to completion of ceusa of death? 24a. Wes en eutopsy performed? Completed Deen hes 1 ☐ Yas 2 ☐ No 1 ☐ Yes certificate Division of Vital funeral director, Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axaminar? Hospital: Inpatiant Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No To 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Dey Yeer) 27. Mannar of Death 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. injury et Work? Certification: al or Attending P s after death.

I Director: After t d in by the funers Naturai Accident 5 Panding invastigation 1 Yas 2 No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and pieca, end dua to tha causa(s) and menner es steted.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated. 29a. Certifian edical (Check only one) 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of cartifiar 7,2000 30. Name and eddress of person who completed cause of daath (Itam 23e) (Type, Print) BACTIMORE MO 361 ST PAUL PLALE COSMA

DHMH 16 Rev 6/95

State

Registrar

31. Deta filed (Month, Dey, Year)

FEB 1 1 2000

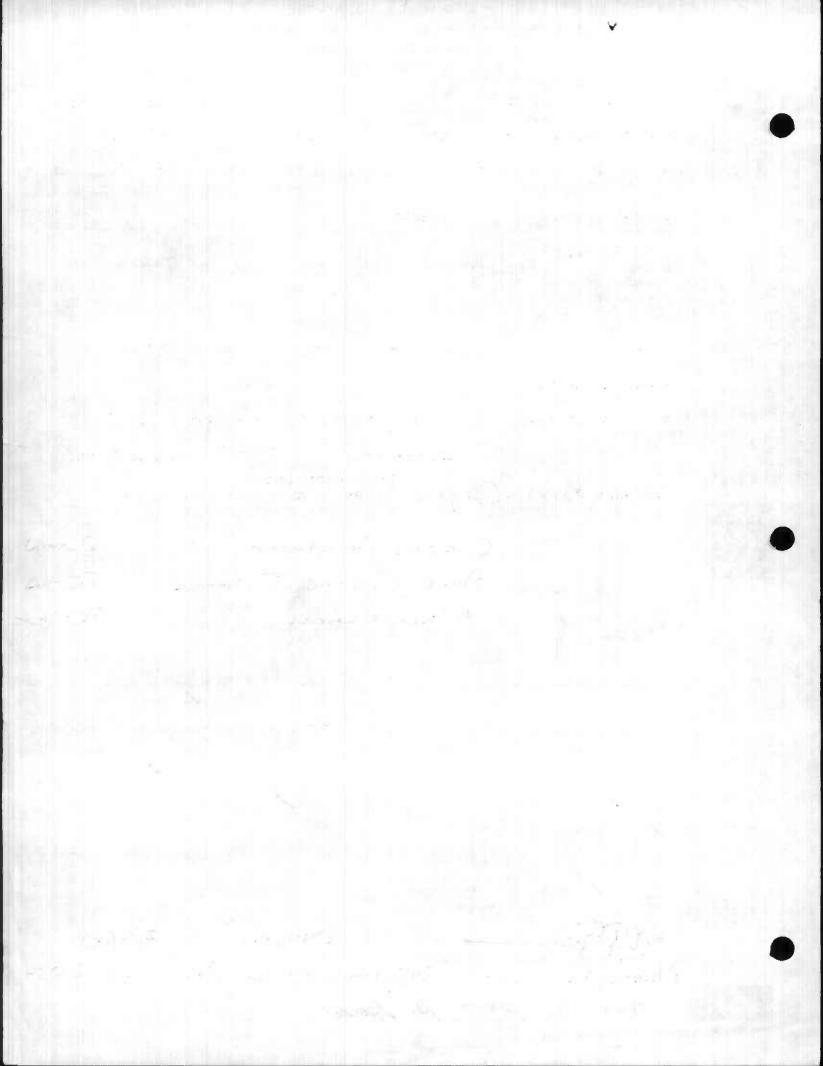
32. Ragistrar's Signature

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| | 1. | Decedent's No | ame (First, Mic | ddle, Last) | | | 06 | ertificat | COIL | Jean | | 2. Date of D | | | | 3. Time of Death |
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| | | enesis | Elder | care 6. Se | | | OOGS yrs. lest birthdey |) If Under | | altiπ If Under | 24 Hrs. | 8. Date of B | | Balti | | place (Stete or Foreig |
| | 2. | 37 18 3 | 1115 | 1 | M 2□ X F | 83 | Yrs. | Months | Deys | Hours | Min. | June 3 | 3 19: | 16 | Nor | th Carolin |
| | | e. State aryland | 10b. Cour | • | | | . City, Town or L el Air | ocation | | | | | | | | 1 Yes 2 No |
| Tallelal Die | 10 | e. Street and I | | | | | | 10f. Zlp | | | | | | itizen of W | Vhet Cou | untry? |
| | | Marital Statu | ole Cou s arried 2□ M | | 12. Was Dec Armed Fo 1 ☐ Yes | orces? | n U,S. 13 | If Yes, spec | dent of H cify Cuba | ispenic Or in, Mexical | lgin? (Sp n, Puerto | ecify Yes or No Rican, etc.) | | | e - Amer k, White | ican Indien, , etc. |
| | | 3 Widowe | 4 Divorc | ed | If Yes, Gi Year or D | ve | | 1□ Yes | 2 XNo | Specify: | | | | Specify | Wh | nite |
| | | | 15. Decedoscify only high econdary (0-12 | hest grade | | 1-4or 5+) | (Giv | edent's Usua e kind of wo DO NOT us | rk done | during mos | at of work | king | | Kind of Bu | | ndustry |
| | 17. | Father's Nan | ne (First, Midd | le, Last) | IVA | | Nars | | | 18. Moth | er's Nem | e (First, Middl | | - | | |
| | | nomas (| Cliftor | Gib | bs | | | | | Ali | ce_ | Cahoon | | | | |
| | | | Name/Reletion | | | | | | | | | rel Route Num | | | | ip Code) |
| | | a. Method of E | | | | | b. Placa of Disposemetery, cr | position (Ner | ne of | | el A | ir, Man | 20c. I | nd ZI | City or 1 | Fown, State |
| | | | 2 Cramation 5 Other | | lemovel from | | Gardens o | | | | 2-1 | 2-2000 | Bal | timore | e, Mar | ryland |
| | 21 | . Signature of | Funeral Servi | ce License | 99 | | i | assahn | Fune | ss of Facili | me | | | | | |
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DHMH 16 Rev 6/95



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** 12:35 AM Evelyn Young Bowling Feb. 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1 Magnolia Dr. LaPlata Charles If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs. 219-16-0962 97 Director Sept. 7 1902 MD Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar deeth with the Marylan Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Nems 23s or 28s-1 show any injury or other traumatic event, the Medical Examine (must be northed at DOGS. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Has 2□No Charles LaPlata Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Maple Ave. 20646 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2€ No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Young Bertha Stafford Young 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Davis/Daughter P.O. Box 3 LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) Trinity Memorial Gardens 2/4/00 Waldorf, MD AREHART - ECHOLS FUNERAL HOME, PA 21. Signature of Funeral Service Licenses MOO945 P.O. Box 567 LaPlata, MD 20646 ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediate Causa (Final disaasa or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yee 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: Other: 1 Yes 20 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 5 Pending investigation 1 Delaturai 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Carlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State

Registrar

31. Date filed (Month, Day, Year) FEB 02 2000 32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

29c. Licansa number

29d. Date signed (Month, Day, Year)

with the Maryland

Baltimore, Maryland 21215-0020

The law requires that the deeth cartificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

attending physician and for usa as the burial-transit

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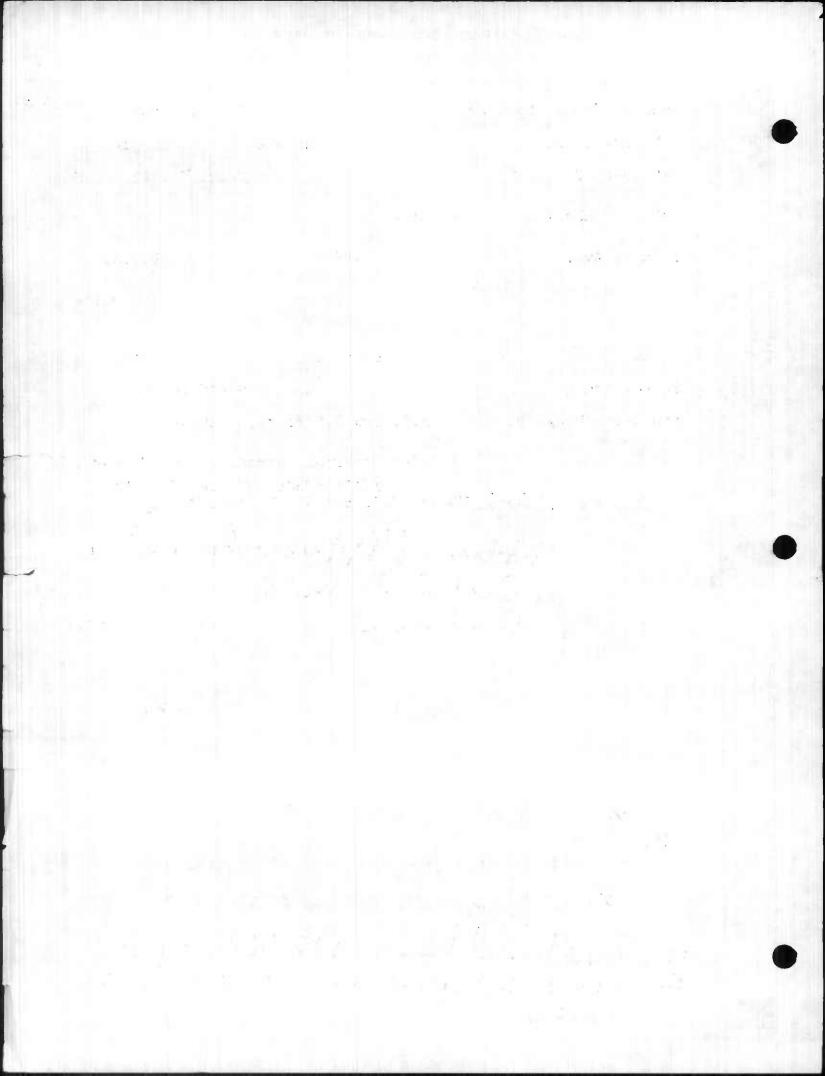
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Helen Irene Burrell /Medical 2000 4c. County of Deeth 11:00 am 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Garrett Co. Mem. Hospital Oakland Garrett 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months 1 M 2 F Yrs Director Dec 24 1909 218-68-2539 Usual Residence of Decedent Md the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Md Garrett Director Kitzmiller 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with PO Box 432 21538 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any finlury or other traumatic event, the Medical Examina Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify. þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Housekeeping 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be John Tasker Caroline Davis P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie Rhodes 445 Fort Ave. Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Jan 30'00 Mt. Zion, Md 21. Signature of Funeral Service Licenses 22. Name end Address of Facility David A. Burdock FH 23a. Part. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death Chronic Obstructive Pulmmar Diseas **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) P.O. Box 68760. that initieted events resulting in death) Last Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Heart ongestine Division of Vital Records, þ page 2 should be 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an eutopsy this certificate has 1 ☐ Yes 2 🗷 No 1 TYPE 2 NO Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Netural 5 Pending Investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide *28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piace, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) P. Daniel Miller 69 Wolf Acres Dr. Oakland, Md. 21550 31. Date flied (Month, Day, Year) JAN 3 1 2000

32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

STERNET MILE DE 11 20184 / 131 /00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Evelyn Dyke 27, January 2000 0300 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Chestertown Nursing & Rehab Center Chestertown Kent 8. Date of Birth (Month, Dey, Year) January 4, 1913 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□M XXF Days Hours Min 87 Yrs. 227-34-2354 Nebraska Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County XX Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 415 Morgnec Road 21620 USA Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 Merried 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Secretary Administrative 18. Mothar's Name (First, Middle, Melden Surneme) 17. Father's Name (First, Middle, Last) George Lanterman Molly Brown 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Robert Allen Dyke/Son 750 12th St. #110, Vero Beach, FL 32960 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation Center, HC 1/27/2000 Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each lina. Approximate fnterval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) 5 days neumonia Dua to (or as a consequence of) Dua to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No

Physician /Medical **Examiner**

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Certification:

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requires that the death certificate be executed

Division of Vital Records, P.O.

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After this funeral

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7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examples, must be notified at

mit. Peges 1 and 2 should be filed within 72 hours after or arriment of Heelih and Mental hygiene. ortant: If New 27 Is marked other than "naturel", or file "Injury or other treumatic event, the Medical Example.

permit. Pege Department o Important: If any Injury or

Baltimore, Maryland 21215-0020

with the Meryland

death

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai

25. Was case referred to medical axaminar?

1 Yes 2 No

27. Mannar of Death

Naturai

2 Accident

3 Suicide

4 Homicide

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

End Stage Alzheimons Douet "-

Hospital:

28a. Date of Injury (Month, Day Year)

1 Inpatiant 2 ER/Outpatient 3 DOA

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

202 No 26. Place of Daath (Check only one)

Othar: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier

5 Pending

investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data end place, and dua to the cause(s) and manner stated. 29c. License number

29b. Signeture end title of certifier

50996

1 Yes 2 No

29d. Date signed (Month, Day, Year) (00)

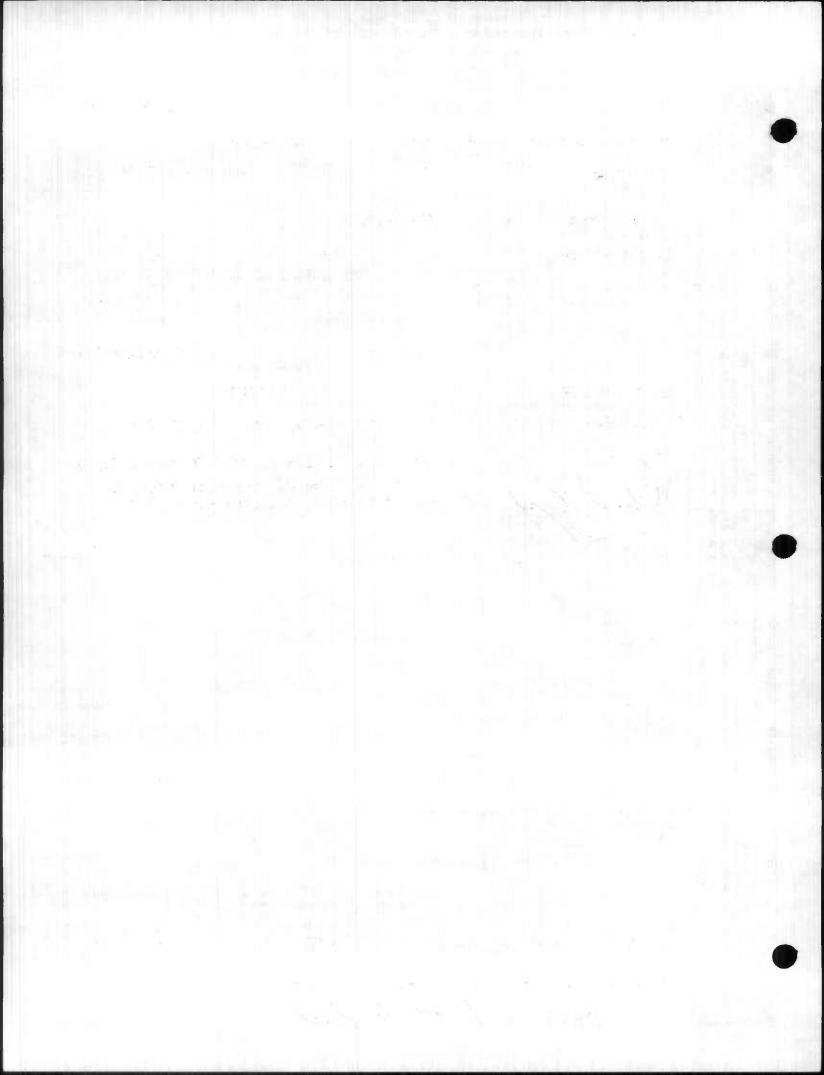
30. Neme and eddrass of person who completed cause of death (Item 23a) (Type, Print)

Neil Stoddard 100 Brown Street, Chestertown, MD 21620 31. Date filed (Month, Day, Yaar) 32. Ragistrar's Signatura

State Registrar

2000 JAN 27

28c. Injury at Work?



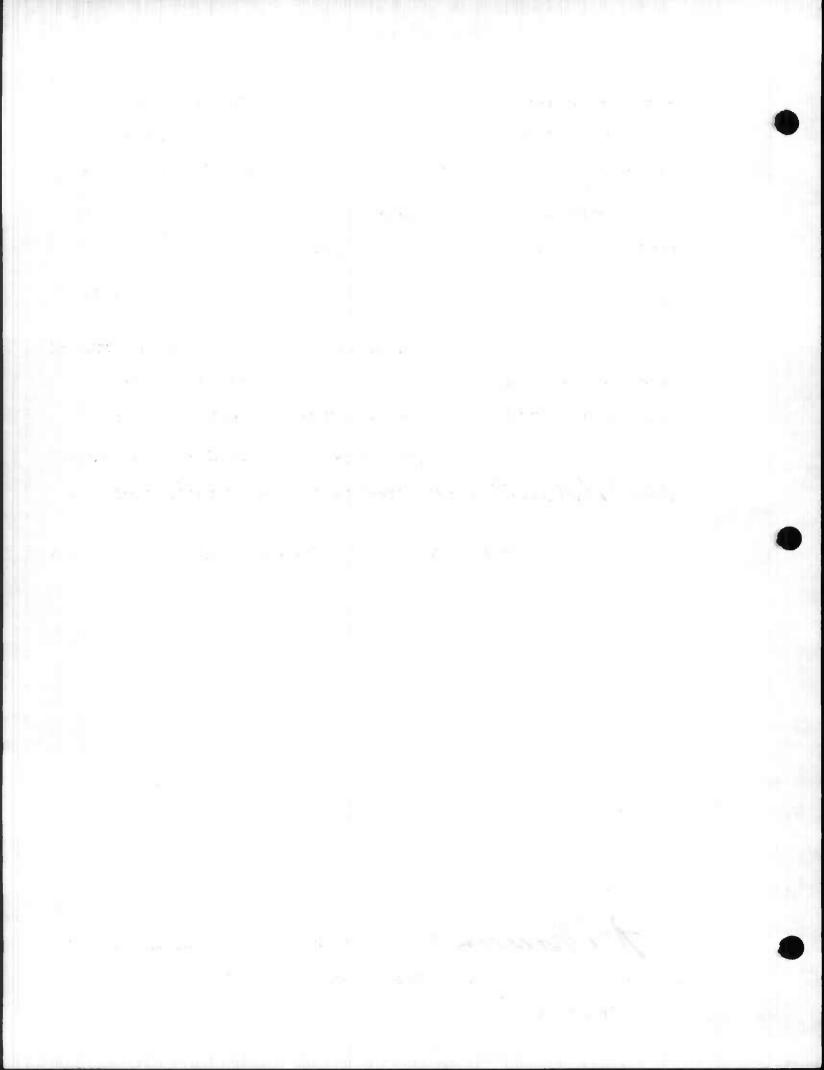
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** JANUARY 26, MARY JANE DeWITT 2000 10:30 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 648 S. THIRD STREET OAKLAND GARRETT 8. Date of Birth (Month, Dey, Yee AUG 11, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 💢 F Yrs. 234-78-8195 86 MARYLAND 1913 Usual Residence of Decedent with the Marylend show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 뛤 it be notified a Director 1 Yes 2 No MD **GARRETT** OAKLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 648 S. THIRD STREET ms 23a 21550 USA Funerai death Herns ? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0020 "natural", or 6 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Buainess/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementery/Secondary (0-12) Collage (1-4or 5+) Hygiene COUNTY GOVERNMENT BOOKKEEPER 7 is marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) Be and Mental HARRY LEE PORTER, SR. SUSIE GEORGINA LITTMAN 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health 8 GEORGE PORTER - BROTHER 537 MONTE VISTA ROAD OAKLAND, MD 21550 item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 X Burial 2 □ Cremation 3 □ Removal from Stete Department important: If any injury or 1/30/2000OAKLAND, MARYLAND 5 Other (Specify) OAKLAND CEMETERY 21. Sign 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 Pert 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting in death) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Due to (or as e consequence of): Examiner The law requires that the death certificate be executed buriel-tren and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in its and as a sequential or injury) Due to (or as a consequence of): Box 68760 Physician/Medicai thet initiated events resulting in death) Lest Due to (or as a consequence of): 9SM P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? should be detact 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7
24 hours efter death.
 Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pendina Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide 1🖄 Certifying Phyalolan: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D07258 JANUARY 28, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) A.E. MANCE, M.D. 3 S. THIRD ST. OAKLAND, MD 21550 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State

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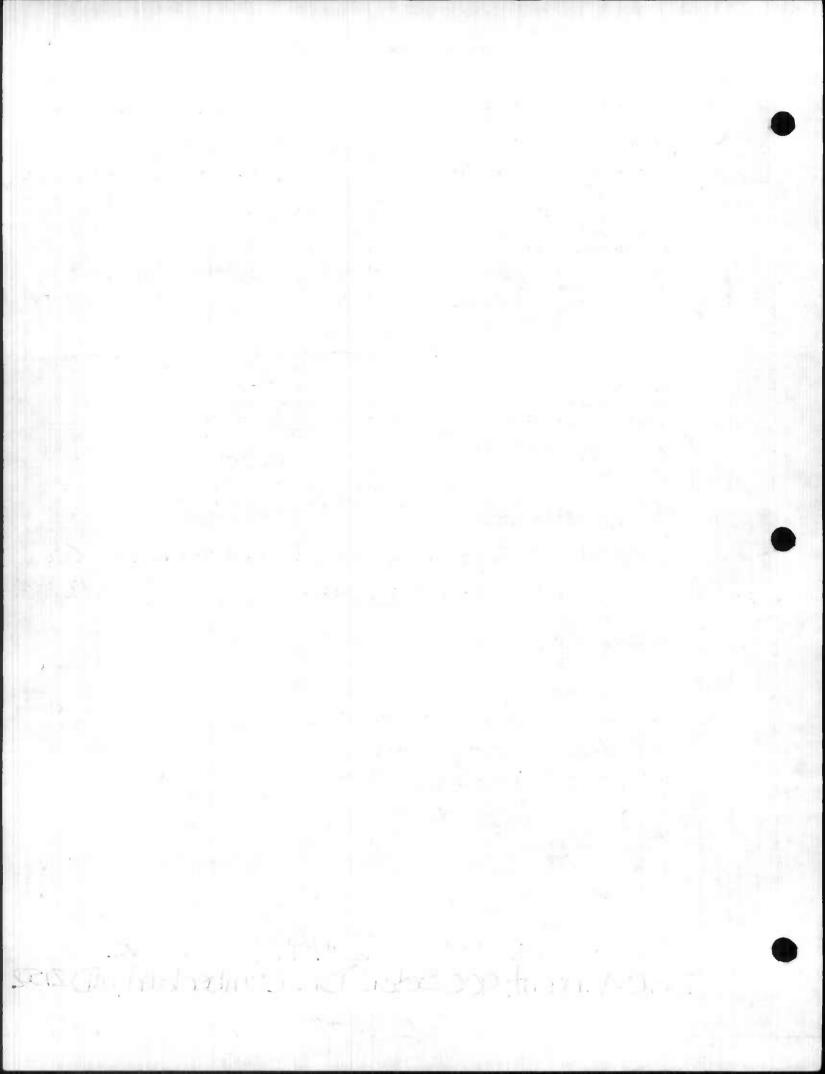
Registrar

JAN 2 8 2000



Please Type or Print in Black Indelible Ink. Assure All-Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedant's Name (First, Middle, Last) 2. Dala of Death 3. Time of Death Day **Physician** tou, Sr. Harrison 6. January 19, 2000 1847 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1√2 M 2□ F 50 Yrs. Director 212-54-8510 Usual Residence of Decedent Aug. 26, 1949 Frostburg, MD 10a, Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD Grantsville Garrett 1 Yes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 12287 National Pike USA matural", or flams 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2□No TYas, Give Yaar or Dalas:Vietnam 1 ☐ Never Married 2 ☑ Married altimore. Maryland 21215-0020 1 ☐ Yes 2 € No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Mechanic M&S Stone Quarry 17. Falher's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 12 should be f. r and Mental F. is marked off Mary Brown 2 James Foy 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 12287 National Pike, Grantsville, MD Department of Health reportant: If Nem 27 Margaret V. Foy, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cem., Jan 22, 2000 Grantsville, MD 21. Signature of Funeral Service License 22. Nama and Address of Facility Newman Funeral Homes, P.A., 179 Miller St., N P. O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Dua to (or as a conseq Examiner entherenceen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed history 0 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital 25. Was cesa rateriod in medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After Attending 1 Natural 5 Pending investigation or Attending after death. Director: After 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 94 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifige 29c, License numbe meus January ZZ 2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

DHMH 16 Rev 6/95

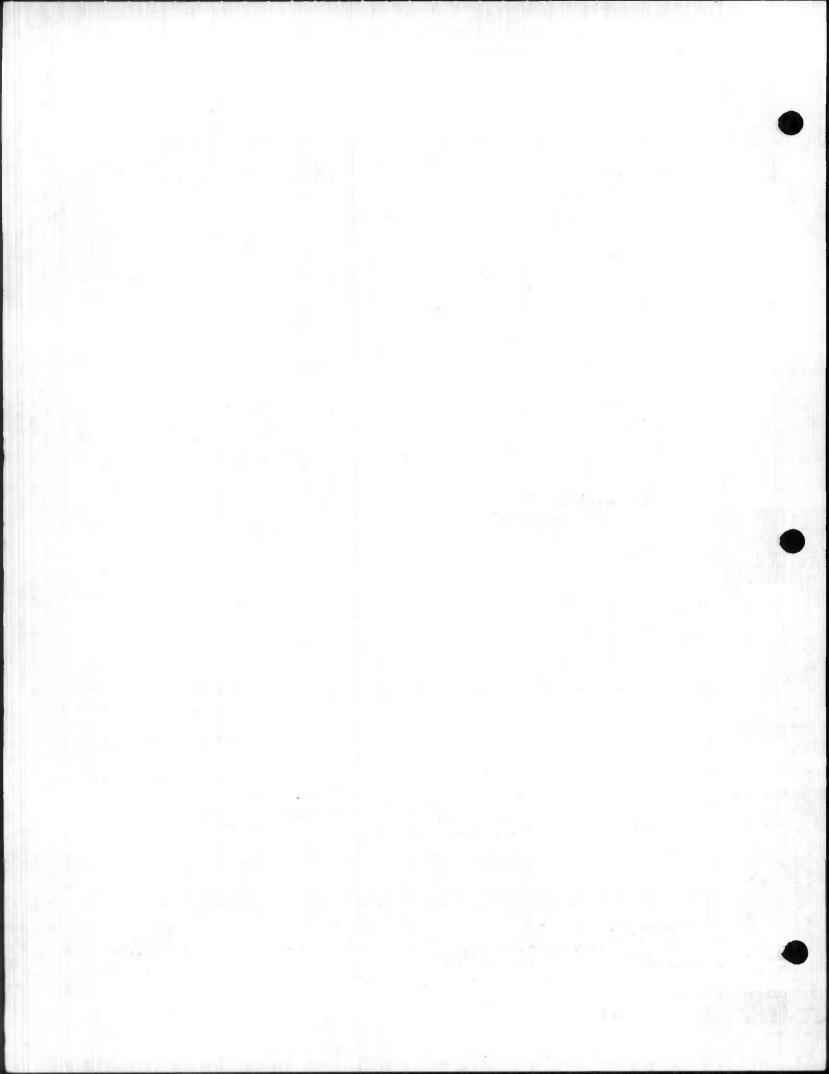


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Lest) 2. Data of Death **Physician** Month 2000 26; Anna M. Gregory Jan. 11:25P.M /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cuppett Weeks Nursing Home Oakland Garrett Hours Min. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 □ M 2 1 F Days Yrs. Director 216-28-4165 81 Usual Residenca of Decedant with the Marylend 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show "natural", or items 23a or 28a-f shorical Examiner must be notified Director 1 N Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 1923 Engla Ave. 21207 USA Funeral Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene. 12. Was Dacedent Evar in U,S. Armed Forcas? 1· ☐ Yas 2 ☒ No tf Yas, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 □ Navar Married 2 □ Marriad Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: Completed by 3 XWidowad 4 ☐ Divorced The Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) lith end Mental Hygiene. 27 is marked other than "r r traumatic event, in Med Elemantary/Secondery (0-12) College (1-4or 5+) 7th Housewife Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be UNKNOWN UNKNOWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Health e 21550 If item 27 or other t Joe Gregory/Son P.O. Box 381, Oakland, Md. 20b. Placa of Disposition (Nema of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Othar (Spacity) St. Stanislaus Cemetery 1/29/00 Baltimore, Md. 21. Signature of Funaral Sarvice Licansea 22. Nama and Addrass of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 23e. Part 1. Enter the diplasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respirelory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediete Ceusa (Final diseasa or condition resulting in death) a Acute Myocardial Infarction 2 Days Examiner Dua to (or as e consequence of): Examiner Coronary Artery Disease Years or Attending Physician: The lew requires that the death certificate be executed the burial-transit Sequantielly list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last and Due to (or as a consequence of). P.O. Box 68760. Physician/Medical Due to (or as a consequence of): USB BS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? s been signed by the should be detach. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Mesenteric Infarction Division of Vital Records, þ 24b. Ware eutopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 2 No this certificate 1 Yes 1 ☐ Yas 2 No funeral director, Be 25. Was casa rafarrad to medical axaminer? 26. Placa of Death (Chack only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA 27. Mennar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pending Investigation efter death. 2 Accidant 1 Yes 2 No the 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicide 24 hours e Hospital TO Certifying Physician: To the best of my knowladge, deeth occurred at tha time, dete and place, and dua to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of my knowladge, deeth occurred at tha time, dete and place, end due to the causa(s) and manner stated. Medicai 29a. Certifian To the within 2 29b. Signatura and the certifier 29c. Licansa number 29d. Dala/signed (Month, Day, Year) 40 D0033464 w 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Robert M. Coughlin, M.D. P.O. Box 8, Eglon, WV 26716 31. Dele filed (Month, Day, Yeer) 32. Registrar's Signatura State **JAN 28** Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year Alma Mildred Kronau 9:06 p.m. January 25, 2000 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Kennedyville Kaufmans Care Home Kent If Linder 1 Yee Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Months Days 1□M 2X F Hours 218-14-1194 92 July 2, 1907 Baltimore, Maryland Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Kent Still Pond 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Royal Swan Farm, PO Box 114 21667 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3℃Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 12 Own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Thomas Emmart Alma Joyce Ford 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Kronau Quarstein/Daughter 4202 Chesapeake Avenue, Hampton, Virginia 23669 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 1/26/2000 Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediete Ceuse (Final ARDIO Pulmonary disease or condition resulting in deeth) Myscardial Inparction Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Dun of tor es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

Box 68760

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25. Was case referred to medical 1 Yes 2 No 27. Manner of Deeth

1 DNature! 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28e. Date of Injury (Month, Dey Year)

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes

2 🗆 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner steted. 29b. Signeture end title of certifie

29a. Certifier

(Check only one)

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of deeth (Item 23e) (Type, Print)

29c. License number

29d. Date sigped (Month, Dey, Year)

State Registrar

Medical

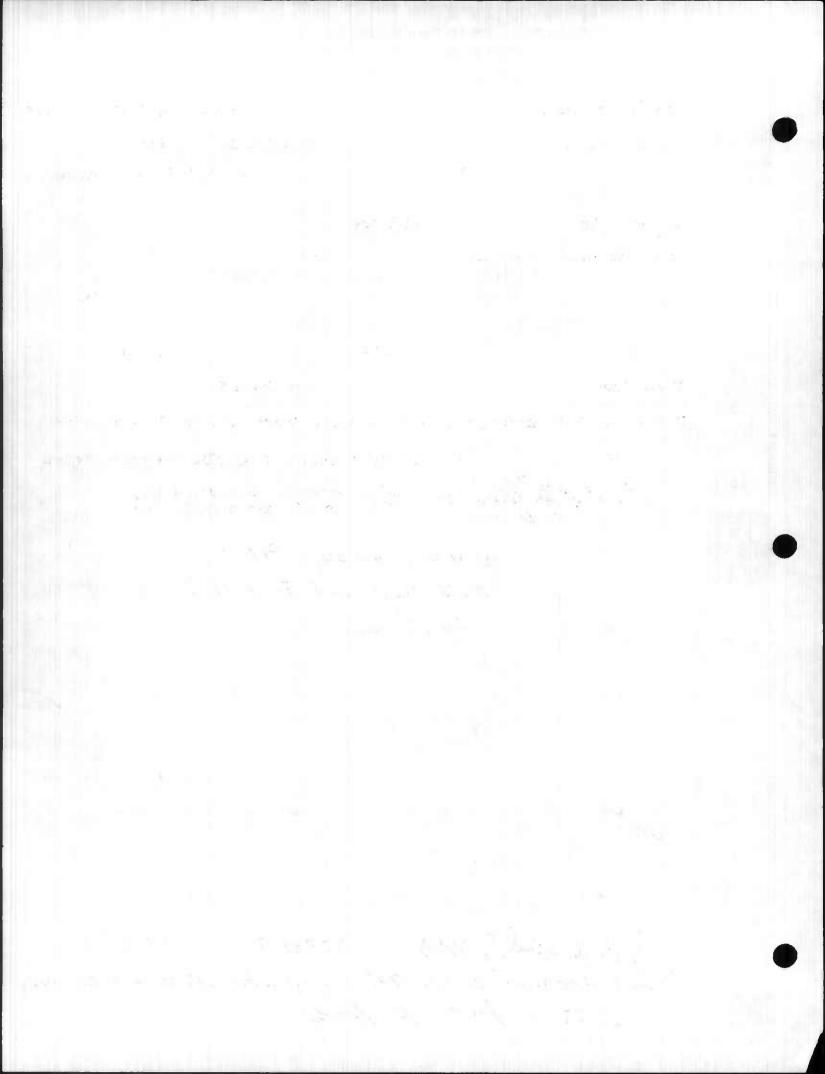
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31. Date filed (Month, Dey, Year) **JAN 27** 2000

30. Name and eddress of person who completed cau

32. Registrer's Signeture

948 WAShington Ave, Chester form Wed 2/620



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death January Day Jear 29 2000 1. Decedent's Name (Fjrst, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 23 ar 150 H 01 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEAlth of Southern Mary Inna! 5E0898 6. Sex 1 M 2 ☐ F 5. Social Security Number Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 9 Yrs. Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MARLIAND FRINCE JEDEGE 10a. Street and Number 10g. Citizen of What Country? 10f. Zio Code Shapieo De. # 135

12. Wes Decedent Ever in U.S.
Armed Forces?
1 Ayes 2 No
If Yes, Give
Year or Dates: 1943-45 1329 20735 8500 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural", or iten any injury or other treumatic event, tre Medical Examinations. Black, White, etc. 1 Never Marriad 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOYERNMENT 12 TEDERA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milliam FANNIE MINKNEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Clinton, MD 20735 De#1329 20b. Place of Disposition (Nama of cemetery, crematory or other place) beeta THADIED 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 □ Other (Specify) ETERANS (Em. heltenham, M 21. Signature of filmeral Service-Licansee 22. Name and Address of Facility 20608 HOURSCO, MI M0019 Hdams tuneral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final ASUVID 40015 disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): Keepel h P.O. Box 68760, CVA Physician/Medical Due to (or as a consequence of): year IN Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Whiknown 1 Yes 2 No Records, Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 Ho 2 10 No Division of Vital or Attending Physician: 25. Was casa raferred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yas 2 10 NO 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturat 5 Pending 1 Yes 2 No 24 hours after death. Puneral Director: A investigation 2 Accidant 6 Could not be determined 28e. Place of Injury - At homa, farm, street, tactory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) Iscataway 9131

DHMH 16 Rev 6/95

State

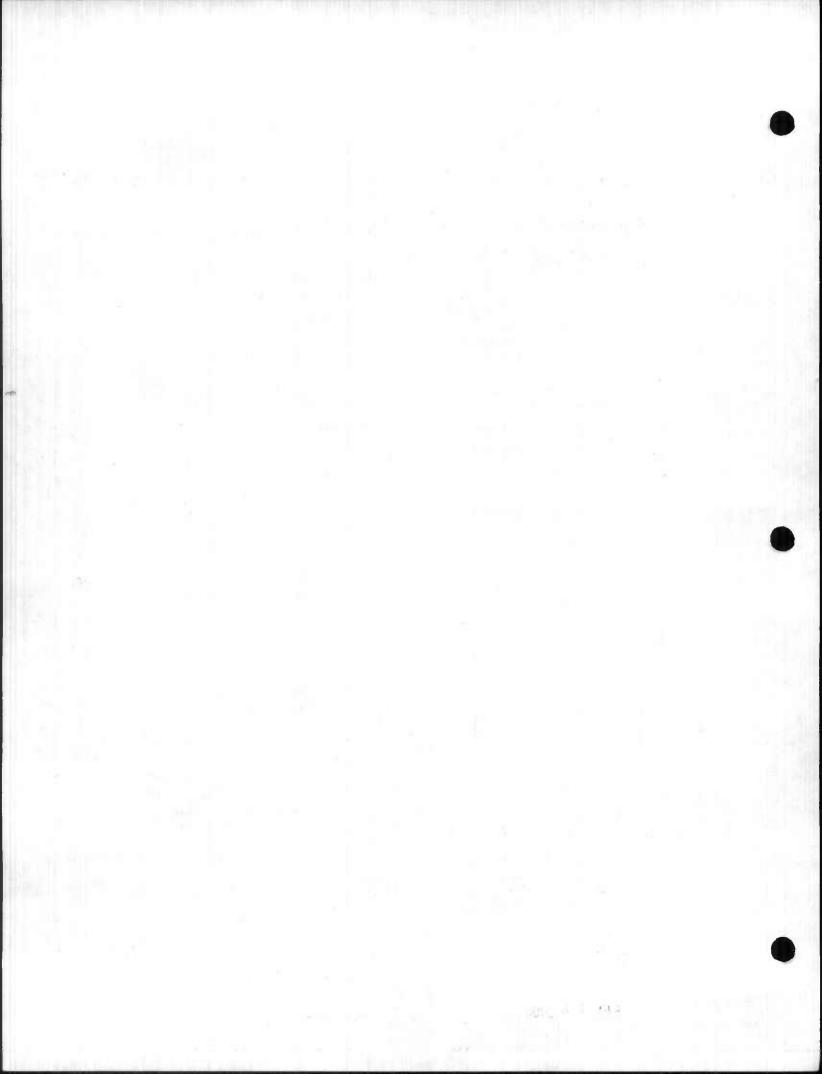
Registrar

31. Deta filed (Month

FEB

32. Registrar's Signature

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Maud Katherine McTague January 28, 2000 12:45p.m. 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Death Kent & Queen Anne's Hospital Chestertown Kent If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) March 30, If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign 1□ M 20 F Months Deys 78 Yrs. 1921 Pennsylvania 194-12-1099 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Queen Anne's Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 117 Justin Buch Drive 21620 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 DX'es 2 □ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2XXNo Specify: White 3\OWidowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Horace O'Neil Katherine Vironcia Hackney 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Kathleen B. McLaughlin/Daughter 117 Justin Buch Drive, Chestertown, Maryland 21620 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Crumpton Cemetery 2/2/00 Crumpton, Maryland 21. Signeture of Funerel Service Ligar 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. hr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately that the disease of the dise Approximete intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) CARDIO Pulsumany Are Rost Acute Myocarden Tufantin Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Respiratory Failure Due to (or as e donsequence of): Pulmerary End Stage Chiowie OBStructure execuse Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to 24e. Wes an eutopsy performed? History of Congestive Heart Failure And completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes 2 TNo 26. Place of Deeth (Check only one)

Physician /Medical Examiner

that the death certificate be axecuted

Division of Vital Records,

or Attanding Physician:

death.

within 24 hours after death To the Funeral Director: / completely filled in by the

within 2

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

with the Maryland

permit. Pagas 1 and 2 should be filed within 72 hours aftar deeth with the Marylan Department of Haaith and Mantal Hygiane.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic evant, the Medical Experies that be notified an once.

Examine attanding physician and for usa es the bunal-transit Physician/Medical ed by tha si signed by t þ Completed cartificata has t lirector, paga 2 s director, Be 2 funaral

Certification:

Anteus desatie Cardiovas culan 1/25. Was proposed referred to medical Caron any Antenny Hisease 1 Yes 2 No Hospitel:

28a. Dete of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ OOA

28b. Time of

1 Yes 2 No

28c. Injury et Work?

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

(Check only one) 29b. Signeture end title of certifier

27. Menner of Deeth

1 Maturel

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

18 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29c. License number

5 Pending

Investigation

6 Could not be determined

23889

29d. Date signed (Month, Day, Year) 1/28/00

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

M.D. 948 WAShington Aug, Chester town, Ned 21620 TOLOR P. ARKABAC M. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

State Registrar

2000

Stage By The DERS LE WAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 2:30 PM JANUARY 2000 MICHAEL MYLES 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE ANNE ARUNDEL | GLEN | 8. Data of Birth | 9. Birthpleca | Stare Star NORTH ARUNDEL HOSPITAL 6. Sex 1X M 2□ F 5. Social Security Number 7. Aga (In yrs. last birthday) Months 216-50-5053 Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7933 Stonehearth Drive 21144 USA 14. Race - Amarican Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Nevar Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) N/A 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Ruth Evelyn Moore John Joseph Myles 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) James Myles/Brother 12864 Tern Crt. Lusby, MD. 20657 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Crametion 3 □ Ramoval from Stata Charles Glymont 2/2/00 Indian Head, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee AREHART-ECHOL'S FUNERAL HOME, P.A. 23a. Part1. Enfar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onsat and Death Immediata Causa (Final diseasa or condition rasulting in death) Disense Dua to (or as e consequence of) Dua to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings availabla prior to completion of cause of death? 24a. Wes en autopsy performed?

Physician /Medical Examiner

Box 68760,

P.0.

Division of Vital Records,

Examiner

Physician/Medical

by

nt of Health :

Department of Important: If any injury or

Physician

Examiner

Funeral

Director

28a-f show

must be n

the Medical Exerci-

filed within 72 hours after

Directo

Funeral

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Completed

/Medical

The law requires that the death certificate be executed pue USB. Medical Certification: To Be Completed or Attending Physician: funeral director, this After ! To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A the completely filled in by

Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last Part ff. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yas 2 No 1 Yes 2 No 25. Was casa referred to medical examiner?
1 ☐ Yas 2 ② No 26. Placa of Deeth (Check only one) Hospitel: 1 Inpatiant Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accident Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - Af homa, farm, street, factory, office building, atc. (Specify) 4 I Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian (Check only one)

State Registrar

31. Data filed (Month, Dey, Year) 2 2000

29b. Signatura end titia of certifier

32. Registrar's Signature

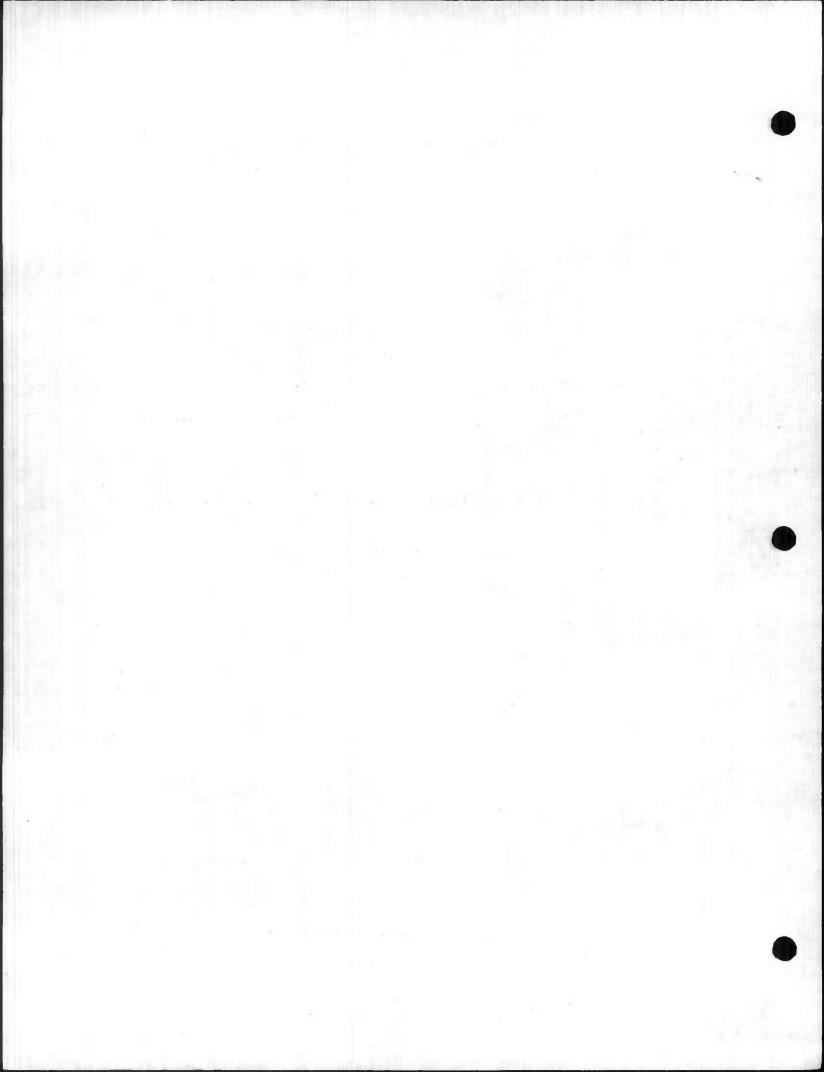
30. Nagra and addrass of person who completed causa of death (Item 23a) (Type, Print)

29c. Licansa number DY134S

Waspital Drive, MD.

29d. Data signed (Month, Day, Year)

Jamay



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death January 19, 2000 Violet Smith Stubbs 12:16 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 105 Charles Street Sudlersville Queen Anne's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | October 28, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2XXF Months 215-20-0038 78 Yrs. Maryland Usuai Residenca of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No Maryland Queen Anne's Sudlersville 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? 105 Charles Street APt. 2 21668 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes XNo Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Smith Anna Buckel 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lee Clark/Daughter 7183 E. Ranier Driver, Parsonsbury, Maryland 21849 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation /5 ☐ Other (Specify) Sudlersville Cemetery 1/22/2000 Sudlersville, Maryland neral Service Licenses 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. B70 W. Cypress Street, Millington, Maryland 21651 cause on each line. B70 W. Cypress Street, Millington, Maryland 21651 A Approximate Interval Between Onset and Deeth Immediate Cause (Final) Cardro Pulmer and Due to (or as a consequence of): disease or condition resulting in deeth) te Myocardial Fufanctian Due to (or es Joonsequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Flu Syndione Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Sesease, Hyperteuses Candiovasculan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hoppen cleales teraleun 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Department of Important: If any Injury or DAGS.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Example: must be notified at

I Hygiene.

.. Pages 1 and 2 should be filled wi fment of Heelth and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

Directo

Funeral

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Completed

the Maryland

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death

altimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Examiner

physician and the burial-transit 98 980 ō the signed by peed page 2 certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice

Physician/Medical þ Completed Be 10 Certification:

25. Was case referred to medical

29b. Signature and title of certifier

1 (Natural

3 Suicide

29a Certifier

5 Pending 2 Accident 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year) investigation

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

948 WAShington Ave, (Kesten form Hed 21020 Annasme 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 4 2000

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** January 22 2000 ETHEL BURRIS SHELTON 6:00am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Magnolia Hall Nursing Home Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 5 1904 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 95 Yrs. Director 212-18-6871 Aug Maryland Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f ehor the Medical Examiner must be notified at 1 Yas 2 No MD Directo Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Charles St. 21668 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Giva Year or Dates: 1 Nevar Married 2 Married b Baltimore, Maryland 21215-0020 1 Yas 2X No Specify: white Specify: à 3 X Widowed 4 ☐ Divorced Completed Hygiene Hygiene other than *natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permil, Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If them 27 is marked other tha any Injury or other iss Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Andrew Burris 2 Georgia Anna Starkey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Yeager (gr-daughter) 10554 Big Stone Rd. Millington, MD. 21651

20a. Method of Disposition

20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Massey Cemetery 1/25/00 Massey, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21, Signatore of Funeral Service Licens 22 Name and Address of Facility Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. Part Enjer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock of heat failure. List only one ceuse on each line. Approximate tntervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Breast Cancer 6 years disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last and Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): 93 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown P Congestive Heart failure 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was en autopsy performed? Completed 22 No certificate 25. Wes cese referred to medicel examiner?

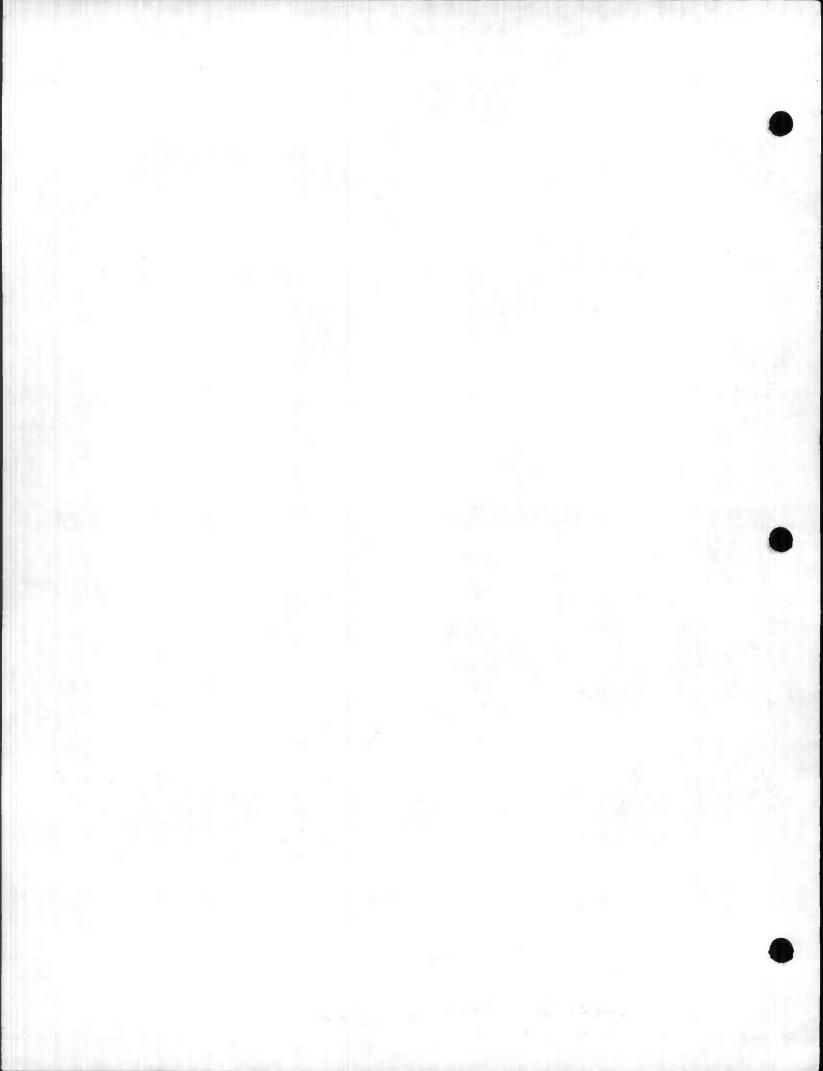
1 Yes 2 No 8 26. Place of Death (Check only one) Hospitat: Other: Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After To the Mospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending 2 Accident invastigation 1 Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the causa(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) end manner as stated. edical 29a. Certifier (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and hitte of certifier 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) ANDREW FERGUSON M.D. 120 SPEER RD SUITE IT CHESTERTOWN MY 21620 JAN 24 2000 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year Raymond Morris Smith January 2000 0230 hrs 21, 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death 1626 Barclay Road (AT HOME Queen Anne's Barclay Birthplaca (State or Foreign Country) If Undar 1 Yeer | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 5. Sociei Security Number 6. Sax 8. Data of Birth (Month, Day, Year) 1₩ 2□ F Davs Months Hours June 15, 1938 Maryland 218-34-8105 61 Usual Rasidance of Dacedent 10a, Stata 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yas 2 No Barclay Oueen Anne's Maryland 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21607 PO Box 41 1626 Barclay Road 13. Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 14. Race - American Indien, Black, Whita, atc. 11. Maritel Status 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Contractor Plumbing & Heating 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middla, Meidan Sumeme) Sarah G. Green Morris T. Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code 21607 1626 Barclay Road, PO Box 41, Barclay, Maryland Barbara Smith - Wife 20b. Place of Disposition (Nama of cametery, cramatory or other place) January 26, 2000 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Chester, Maryland Chesapeake Cremation Center, LLC 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensae Fellows, Helfenbein & Newnam Funeral Home, P.A. Fellows, Helfenbein & Newram Funeral Home, P.A.

370 Cypress St., PO Box 270, Millington, Maryland 21651

Approximate shock, or haar failure. List only on a ceuse on each line. Approximate Intervel Batween Onsat end Death LUNG CANCER > 3 mo Immediata Causa (Final diseese or condition resulting in death) Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury thet Initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequance of) Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 ☑ Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medicei axaminar? 26. Placa of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Deeth 28c. Injury at Work? 28b. Tima of 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No

certificate be executed Box 68760 Division of Vital Records, P.O. or Attending hours after death.

Examiner ician and bunal-trans Physician/Medical the 80 950 signed t filled in by

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

7 is marked other than "naturel", or Nema 23a or 28a-f show treumetic event, the Medical Examiner must be notified at

nit. Pages 1 and 2 should be filed within 72 hours efter carment of Heelth and Mentel Hygiene.

ortant: if item 27 is marked other than "naturel", or ites injury or other treumetic event, the Medical Examine.

permit. Page Department of Important: If eny Injury or pace.

Physician

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Examiner

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After this

24 hours Hospital

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Baltimore, Maryland 21215-0020

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Certification: To

Medical

29a. Certifier (Check only one)

2 Accident

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3 Suicida

1 Cartifying Physician: To the best of my knowledge, daath occurred et tha tima, dete end plece, and dua to the causa(s) end mennar es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated.

29b. Signature end title of certifier

6 Could not be datamined

When my

29c. Licansa number

29d. Data signed (Month, Day, Year) 00

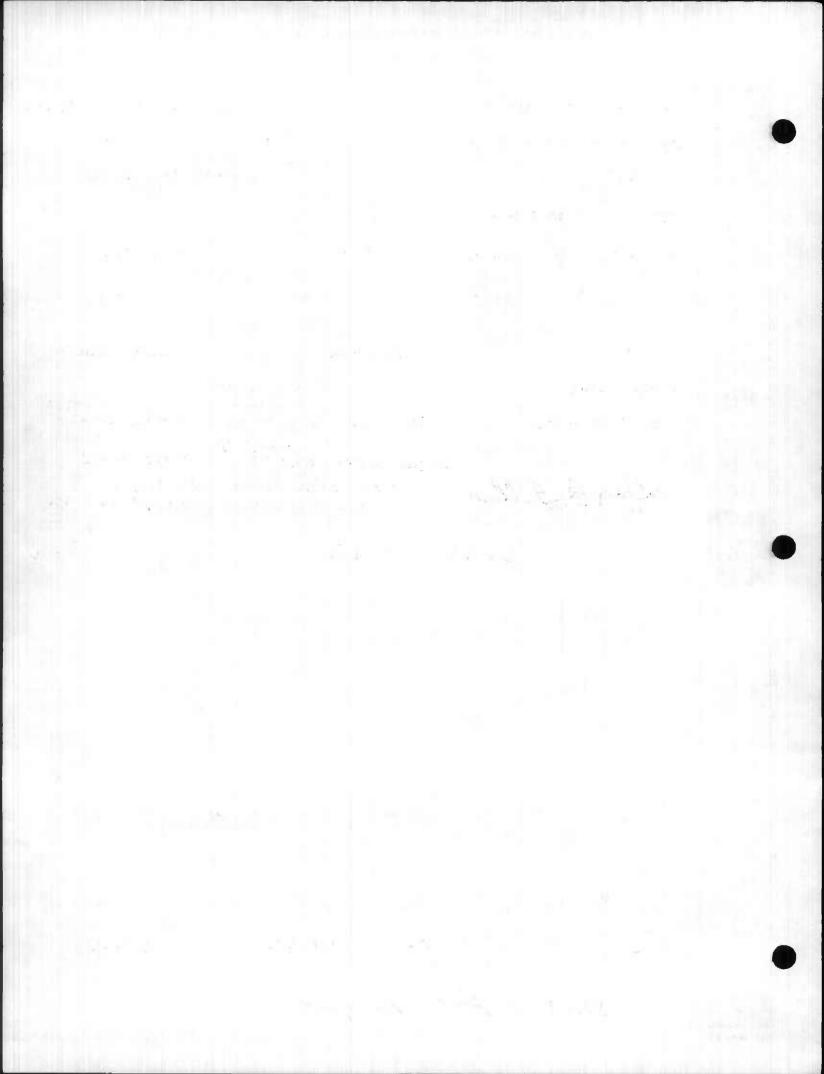
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

Noble, 122 Speer Rd., Suite Chestertown, MD 21620 2 7 2000 32. Registrate Signature

28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

State Registrar



| | | | | | | Cei | tificate | of | Death | F | leg. No. | 0 | 406 | U | | |
|--|-----------|--|------------------------------------|-------------------------------------|---|-------------------------------------|----------------------------------|--|---|---|---|---|---------------|------------|--|--|
| Physiciar | | 1. Decedent's Name (First, Middle, Last) | | | | | | | | 2. Date of Dea Month | th Day | Year | | | | |
| /Medica | | Nancy Lee | e Sutton | | | | | | | January | 25, 20 | 000 | 2:2 | p.m | | |
| Examine | 4.0 | a Facility Name (If | f not institution, g | ive street end nur | nber) | | | | 4b. City, Town, or Lo | ocation of Death | | | | | | |
| | | 233 Longi | fellow D | rive (Re | esider | nce) | | (| Chesterton | | Kent | | | | | |
| Funeral | 5. | Social Security No | | Sex | 7. Age (In | yrs. lest birthday) | If Under 1 \ | Year | | 8. Date of Birth | 8. Date of Birth 9. Birthplace (Ste | | | or Foreign | | |
| Director | | 218-34-87 sual Residence of | 762 | 1 M 2 F | □ M 20 F 59 Yrs. Months D | | | | | 4 Hrs. 8. Date of Birth Min. January 28, 1940 Chestertown, MD | | | | | | |
| 72 hours efter death with the Maryland netural, or items 23s or 28s-f show deal Examiner must be notified at | 10 | Da. State | 10b. County | | 10c | . City, Town or Lo | | | | | 10d. Inside City Limits | | | | | |
| No Maria | 2 | Maryland | Kent | | | Ches | tertown | 1 | | | | | | | | |
| or 2 | 10 | De. Street and Num | nber | | 10f. Zip Code 10g | | | | | | 10g. Citizen of \ | 0g. Citizen of What Country? | | | | |
| 23a | 2 | 233 Longi | fellow D | rive | | | | 2 | 1620 | | USA | 1 | | | | |
| r from 23a or 28a-f s | 1 | 1. Marital Status | Armed Fo | rces? | | | | Hispanic Origin? (Sp pan, Mexican, Puerto | (Specify Yes or No- uerto Rican, etc.) | | 14. Race - American Indian, Black, White, etc. | | | | | |
| y work is a root of terms 23s or 28s-1 show the Maryes than 'natural', or items 23s or 28s-1 show the Maricel Examines must be notified at | 2 | 1 Never Marrie | ed 2□ Married 4ሺ Divorced | 1 🗍 Yes If Yes, Giv Year or D | 1 Tes ATNo If Yes, Give Year or Dates: | | 1 ☐ Yes XXNo Specify: | | | | Specify | Specify: White | | | | |
| natur | Completed | (Speci | 15. Decedent's lify only highest g | | | 16a. Dece | dent's Usuai C kind of work o | occu | pation during most of work ed) | ing | 16b. Kind of B | usiness/Industry | | | | |
| than | 1 | Elementary/Secon | ndary (0-12) | College (1 | -4or 5+) | | | | | | Health 4 | 70200 | | | | |
| Hygiene. ott, p.e.M. | | 12 | (Final Add date 1 | 41 | | pi II ing | /Adminst | ra | T | a (First & Side) | Health (| | | | | |
| d out | 0 1 | 7. Father's Name (| | | | | | | 18. Mother's Nam | | | 10) | | | | |
| Mental Mental arked o | 2 | Casper G | | | | | | | | Jouise Jones urel Route Number, City or Town, State, Zip Code) | | | | | | |
| 0 0 0 | | 9a. Informant's Na | | | | | | | | | | | | | | |
| Health em 27 | | Dawn Pati | ricia Ba | yne/Daug | | | | | | | | | | 20 | | |
| Department of Her Important: If item any injury or other once. | 20 | Da. Method of Disp | osition Cremation 3 | Domes t for | State 20 | b. Place of Dispo cemetery, cres | sttion (Neme metory or othe | of or pie | ece) | Date | 20c. Location | City or Tow | vn, State | | | |
| T. F. | | | 5 Other (Spec | | State | Still Por | | | | /28/2000 | Still | Pond. | MD | | | |
| orta inju | 2 | 1. Signature of Fur | neral Service Lice | onsee / | | 22 | . Name and A | Addre | ess of Facility | | | | | | | |
| Department of P Important: If its any injury or of | | b X | 2010 | 2/1/ | 1 | Fe. | llows, | He | elfenbein | & Newna | m Funer | cal Ho | ome, l | P.A. | | |
| - | ١, | 3a Part Enter th | a disassa or od | nolications that o | aucad tha | 130 | O Speed | r] | Road, Che | stertown | , Maryl | and, 2 | 21620 | ite | | |
| Physician | l ° | shock, or hear | rt failure. List onl | y one cause on e | ach line. | deeth. Do not en | er the mode o | ii uyi | ing, such as cardiec | or respiratory ar | 1651, | 1 | IIII GIVAI DE | tween | | |
| | | | | | | | | | | | | | | | | |
| Medical xaminer | d | mmediate Ceuse (I lisease or condition | | , me | tasi | tatic | Colo | n | Canci | er | | 7/year | | | | |
| | | esulting in death) | | | | to (or as a consec | | | | | | | | | | |
| = 5 | | | | | | | | | | | | 1 | | | | |
| in and | S | Sequentialty list con | nditions, | D | Due | Due to (or as a consequence of): | | | | | | | | | | |
| an an an an an an an an an an an an an a | | any, leeding to im ause. Enter Under | mediate rlying | | | | | | | | | | | | | |
| g physician and es the burial-transit | 2 1 | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | | |
| es th | 3 " | | | | | | | | | | | | | | | |
| | 2 | | | d | | | | | | | | | | | | |
| d tor use | 2 5 | art II. Othor alasidi | loant condition- | contribution to d | ath hut act | t reculting to the | ndarkine sa | ee =1 | iven in Part I | 23h Did 4 | ohacco usa co | ntribute to | the course | of death? | | |
| detached | 2 | art II. Other signifi | Can Conditions | contributing to de | satti DUT NOI | resuming in the U | riderrying caus | ae gi | IVOI III FAR I. | | A . | 3. Tima of Death 2000 2:25 p.1 Thy of Death 2:26 p.1 Thy of Death | | | | |
| | | . <u></u> | | | | | | | | 10, | 1 Yes 2 No 3 Probably 4 1 | | | | | |
| | | | | | | | | | | 24e. Wes en eutopsy 24b. Were autopsy fin | | | | | | |
| page 2 should t | 010 | | | | | | | | | perfo | performed? ava | | | to | | |
| has b | 2 | | | | | | | | | | | of d | leath? | | | |
| page | 3 | | | | | | | | | 101 | es ZK No | 10 | Yes D | No | | |
| # 6 | | 5. Was case referr | red to medical | | | | | | 26. Place of Dea | th (Check only o | ne) | | | | | |
| | 0 | examiner? | No | Hospital: | npatient | 2 ER/Outpatier | nt 3 DOA | ther: 4 Nursing He | Home 5 Residence 6 Dother (Specify) | | | | | | | |
| 를 펼 | | 27. Manner of Dea | | 28a. Date | 28a. Date of Injury 28b. Time of 28c. Injury at | | | | | | 28d. Describe how injury occurred | | | | | |
| al Director: After led in by the tunera | 2 | 1 Naturai 2 Accident | 5 Pending investigati | | | | | | ork? □ Yes 2 □ No | | | | | | | |
| ctor: A y the t | 2 | 3 Suicide | be 200 Diago | | | | | | 28f. Location (Street end Number or Rural Route Number, | | | | mber, | | | |
| Direction | 5 | 4 Homicide | determine | buildi | building, etc. (Specify) City or Town, Stete) | | | | | | | | | | | |
| To the Funeral Director: After completely tilled in by the tune | | | | | | | | | | | | | | | | |
| To the Funeral Completely tilled | 2 | 9a. Certifier (Check only | | miner: On the bi | asis of exar | | | | time, date end place, opinion, death occur | | | | | (s) | | |
| the I | | one) | 2,7425 -4111 | | ner stated. | | | | | | | | | | | |
| To H | 2 | 29b. Signature and title of certifier 29c. License nur | | | | | | | | | | 9d. Date signed (Month, Day, Year) | | | | |
| | | Ithen It When wo | | | | | | 00 | 04158 | 7 | 1/2 | -6/1 | 00 | | | |
| | 30 | 0. Name and addre | ess of person who | completed caus | e of death | (Item 23a) (Type. | Print) | | | | | -/- | | | | |
| | | Helen A | | | | | | 200 | atontorm | Manuel am | 1 21620 | | | | | |

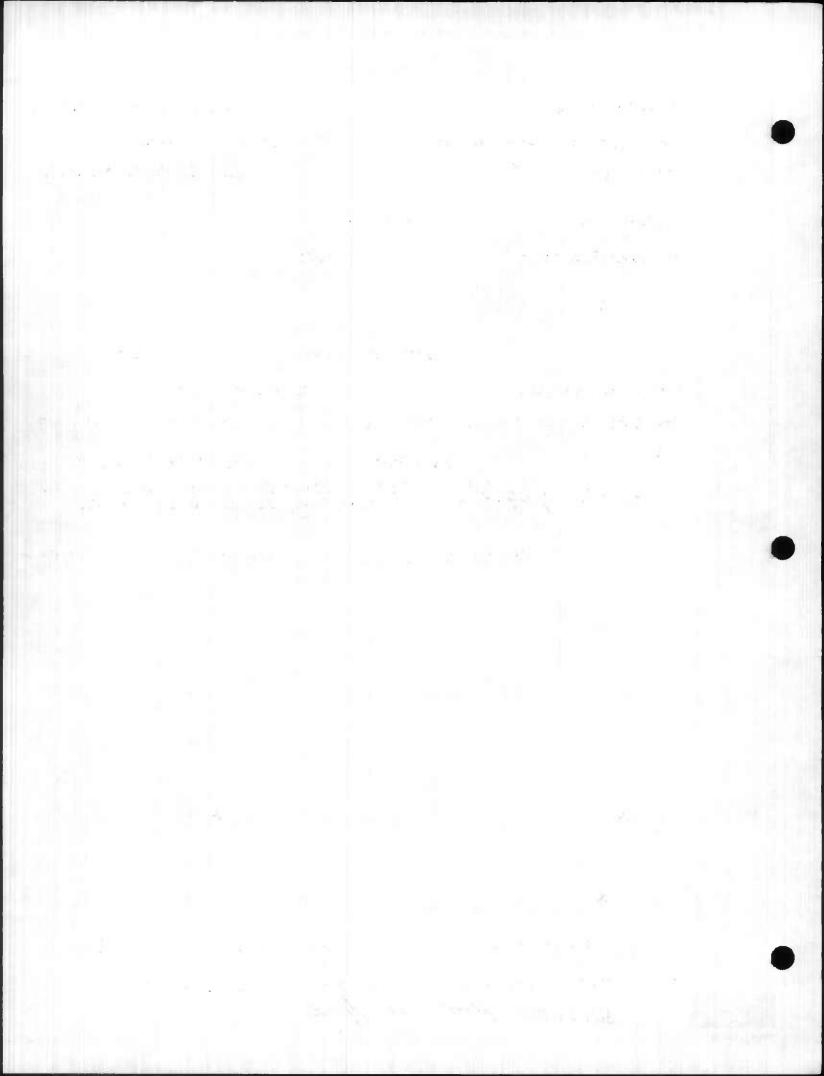
Registrar

State

31. Date filed (Month, Dey, Yeer)

JAN 2 7 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Year **Physician** WILLIAM GRIFFIN JAN 08:33 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) Examiner MARYLAND MEDICAL Solom BALT IMORE

7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth UNIVERSITY
5. Social Security Number Birth 9. Birthplace (State or Foreign Country)

3. 1921 WASHINGTON D.C **Funeral** Days Hours 12M 20 F 579 18 1661 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Director QUEEN ANNES HESTERTOWN 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ROAD 322 RIVER U.S.A 21620 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 by Yes 2 □ No If Yes, Give Yeer or Detes: /941-47 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, Whita, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) REPRESENTATIVE GERBER 12 0 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be PFIEFFER OLINUS CALVERT MARGALET COOPER 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/625 19a. Informent's Neme/Reletionship (Type, Print) RIVER CHESTERTOUN ROA Lois SMITH 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Cremetion 3 ☐ Removel from Stete CREMATORY CHESTER, MD 4 ☐ Donetion 5 ☐ Other (Specify) 100 22. Neme end Address of Fecility 21. Signature of Funerel Service Licensee GREEN HERON WAY 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** PERI FON, tis /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medicai Due to (or as a consequence of). Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Van 2 No 3 Probably 4 Unknown Medical Certification: To

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

288-1

b

flams 23a

natural, or

Saltimore, Maryland 21215-0020

Pages 1 and 2 should be and Mental

mportant: If Item 27 is

| ENC STAGE K | CENAL DIS | EASE | 54 | 24a. Was an eutopsy parlormed? | 24b. Were autopsy lindings available prior to completion of cause of death? | | | | | |
|--|--|-------------------------|--|--|---|--|--|--|--|--|
| 25. Was casa referred to medical examiner? | 26. Place of Death (Check only one) | | | | | | | | | |
| 1 Yas 2 No | Hospitel: 1 Inpatient 2 | ER/Outpatient 3 | Home 5 ☐ Residence 6 ☐ Ott | ne 5 Residence 6 Other (Specify) | | | | | | |
| 27. Menner of Death 1 Netural 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occur | rred | | | | | |
| 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At h building, etc. (Speci | nome, lerm, street, lec | 281. Location (Street end Numi City or Town, State) | RI, Location (Street end Number or Rural Route Number, City or Town, State) | | | | | | |
| | | | | ce, and due to the cause(s) and m curred at the time, date end place, | | | | | | |

State

29b. Signature end title of certifier

29d. Dete signed (Month, Day, Year)

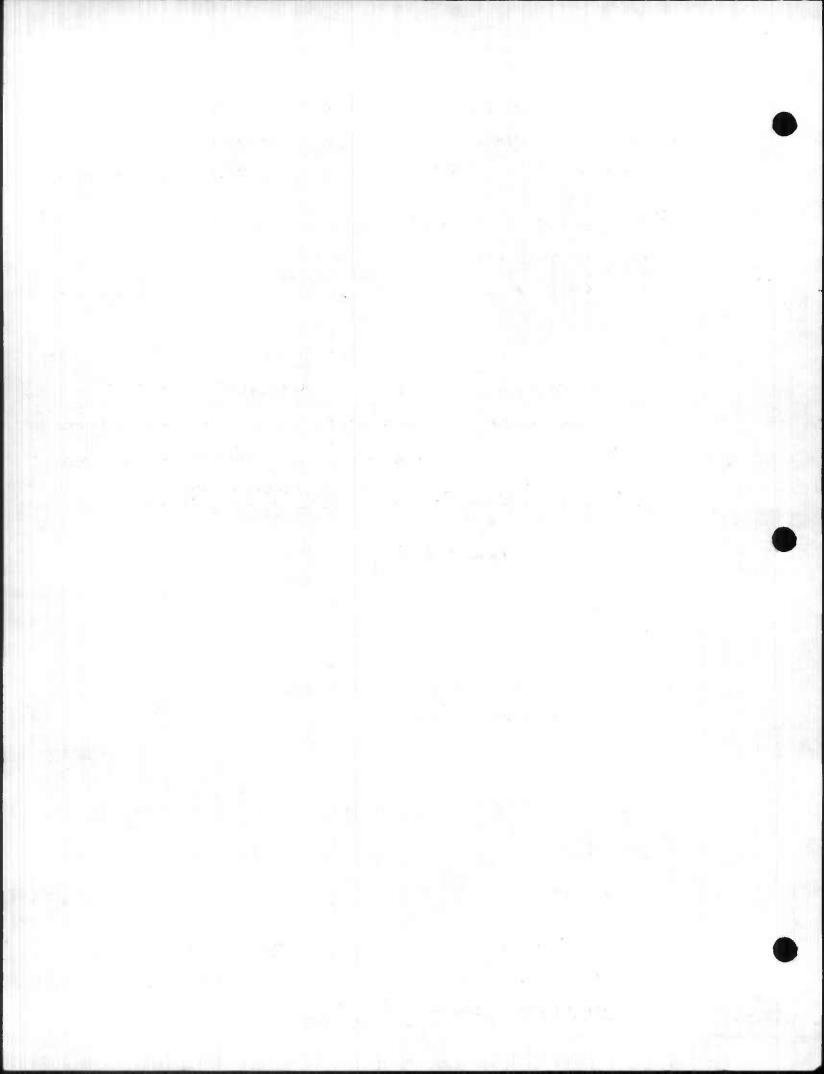
30. Name and address of parson who completed use of deeth (Item 23a) (Type, Print)

GREENE ST. BALFO. MD ZIZOI

31. Date filed (Month, Day, Year) 32. Registjár's Signeture **JAN 31** 2000

29c. License number

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 1:05 a.m. Mildred Marguerite Thompson January 21, 2000 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Chestertown Nursing Rehab. Center Chestertown Kent If Undar 24 Hrs. 8. Data of Birth (Month, Day, If Undar 1 Yaer 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Days 1 M 2 XF Yrs. 1915 Maryland 84 January 27, 214-42-9295 Usual Rasidence of Decedant 10b. Count 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 No Maryland Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 104 Tighman Terrace #116 21617 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14 Reca - American Indian Black, White, etc. 1 ☐ Yas 2 📉 No If Yas, Giva Yeer or Detes: 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama)

Dorothy Elizabeth Abram/Daughter 117 Hill Top Drive, Chestertown, Maryland 21620

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line.

130 Speer Road, Chestertown, Maryland 21620
Approximate Interval Batween Onset and Deeth

Cerebrovascular accident

Due to (or as a consequence of)

Due to (or es e consequence of)

Dua to (or as a consequence of)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Chestistown Nursing

28b. Tima of

Injury OSA M

Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i.

Atrial fibrillation

Dementia

5 Panding

Invastigation

6 Could not be determined

Hypercholes Lero/emia

28a. Date of Injury (Month, Day Year)

21/00

22. Nama end Address of Fecility

20b. Place of Disposition (Nama of cematary, cramatory or other place)

Greensboro Cemetery

Eliza Worthington Ivens

Fellows, Helfenbein & Newnam Funeral Home, P.A.

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda)

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stata

11

20e. Method of Disposition

tmmedieta Causa (Final disease or condition resulting in death)

Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disease or Injury that Initiated avents rasulting in daath) Last

25. Was cesa rafarrad to medical axaminar?

29b. Signetura end titla of certifia

1 Yas No

27 Mannar of Death

Naturel

2 Accidant

3 ☐ Suicide

29a. Cartifier (Check only one)

4 Homicida

William Price Milby

4 □ Donation 5 □ Othar (Specify)

21. Signatura of Fuperal Sarvice Licansaa

Just

19a. informant's Name/Reletionship (Type, Print)

Burial 2 Cramation 3 Ramoval from Stata

Directo

Funeral

à

Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, to the content of the property of the content of

attending physicien end for use es the buriel-transit signed by the a been si should I

Physician/Medical Examine

py

Completed

Be

10

Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate hes b lirector, page 2 s or Attending Physician: this funeral After I Director: A within 24 hours efter To the Funeral Direc completely filled in b

> State Registrar

Hospital:

29c. Licansa number

8 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to the ceuse(s) end mannar as stated.

1 Yas 2 No

Rehab

2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 00

23b. Did tobecco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were eutopsy findings eveilabla prior to complation of cause of death?

natural)

1 Yes 2 No

24a. Was an autopsy performed?

28d. Dascribe how Injury occurred

bed

Chionitown

281. Location (Street and Number or Rural Routa Number, City of Town, Stata)

Other: Nursing Homa 5 ☐ Rasidance 8 ☐ Other (Specify)

26. Piece of Daath (Chack only ona)

20c. Location - City or Town, State

1/24/2000 Greensboro, Maryland

30. Nama and addrass of person who completed ceuse of death (Itam 23a) (Type, Print)

Andrew Ferguson, 120 Speer Road, Chestertown, Maryland 21620

31. Data filed (Month, Day, Year) 32. Registrer's Signature 2000 JAN 24

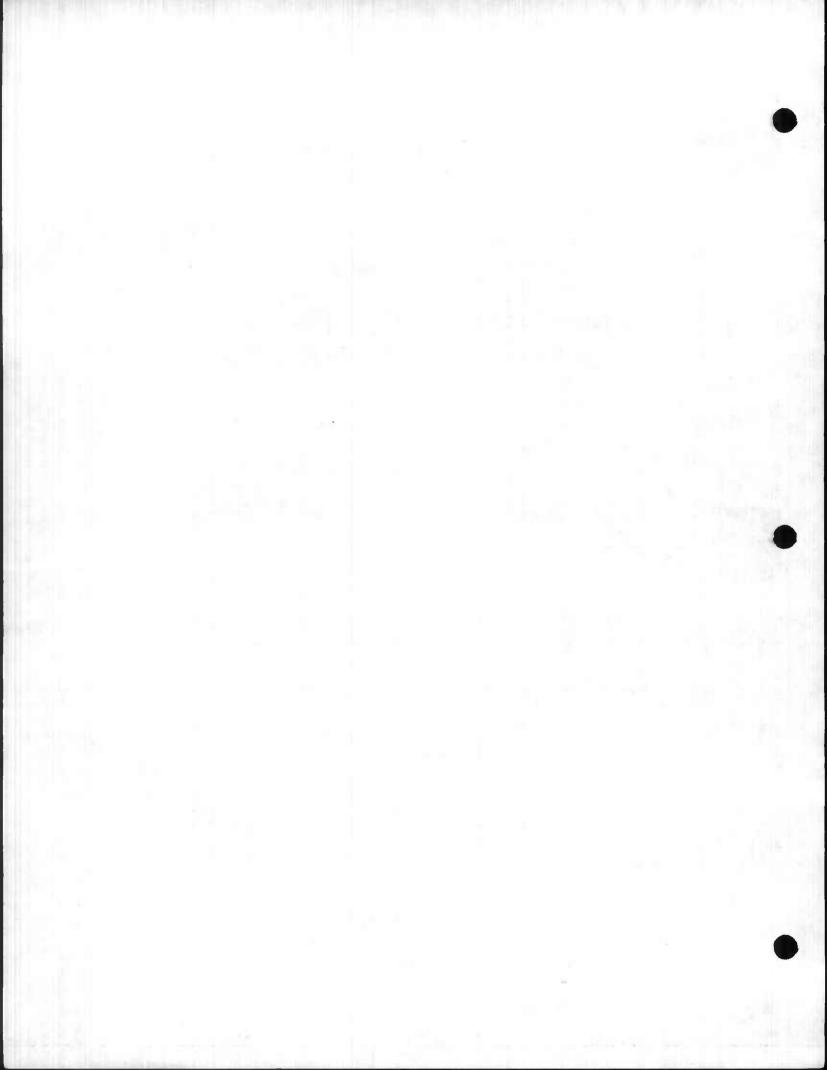
within 2 To the

0

John State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | y.a.ra | | ificate of | Death | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Reg. No. |) [| 14323 | | |
|--|--|--|-----------------------------------|---|---|---|--------------------------------------|---|--|--|----------------------------|---|--|--|
| | Ohi-i | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of De | eath Day | Year | 3. Time of Death | | | |
| | Physician /Medical | Michael Wayne UPOLE, Sr. | | | | | | | | 23, 20 | 11:26 AM | | | |
| | Examiner | Le ci an e l'an la la la la la la la la la la la la la | (If not institution, giv | | | | | 4b. City, Town, or I | ocation of Deat | h 4c. County | of Death | | | |
| _ | | | sity of M | | | | ff Under 1 Year | Baltim | | | timo | | | |
| | Funeral Director | 5. Social Security 217-74-9 Usual Residence of | 9344 | ex 7. ☑M 2☐F | Age (In yrs. las | Yrs. | Months Days | | (Month, De | 8. Date of Birth (Month, Day, Year) May 31, 1960 9. Birthplaca (State or Foreign Country) Maryland | | | | |
| The Maryland 28s-f show polified at | D B H | 10a. State | 10b. County | | 10c. City, | Town or Loc | ation | | | 10d. Inside City Limits | | | | |
| | Man To | MD | Garre | t | | Deer | Park | | | | | 1⊈ Yas 2 No | | |
| | vith the Ma t or 28s-f a be notified Director | 10e. Street and Number 10f. Zip Code | | | | | | | | 10g. Citizen of What Country? | | | | |
| | Par di mi | 26 Tills | son-McGrav | v Street | | | 23 | 1550 | | U | SA | | | |
| 21215-0020 d within 72 hours after death with the Maryla plane, plane, "natural", or hams 22a or 28e-f ahon the Medical Examiner must be notified at | 72 hours after death v "natural, or Nems 22a felical Examiner must leted by Funeral | | ried 2 Married 4 Divorced | 12. Was Decede Armed Force 1 [] Yes 2 If Yes, Give Year or Date | es? ဩ No | | as Decedent of P Yes, specify Cub | dispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No o Rican, etc.) | Specify: | k, White, | can Indian, etc. ite | | |
| 5 | rz ho | /Sne | 15. Decedent's En | fucation | | 16a. Decede | nt's Usuel Occup | pation during most of wor | tina | 16b. Kind of Bu | siness/Inc | dustry | | |
| 2 | and within 72 ho ygiene. wer than "naturn it, the Medical. Completed | Elementary/Sec | | College (1-4 | or 5+) | life. D | O NOT use retire | d) | KIII G | | | | | |
| CA | Hygier III | 121 | | | | Schoo | 1 Bus Co | ntractor | | Board o | | ucation | | |
| E | m sess | | (First, Middle, Last, | | | | | 100000 | 10, 10, 100 | , Maiden Sumam | 9) | | | |
| ž | 2 should by and Menta is marked is marked To E | | Henry Up | | | 404 44-11 | Add (Ct) | | Lee Hinebaugh ural Route Number, City or Town, State, Zip Code) | | | | | |
| Ma | の日本書 | | lame/Relationship (Upole/W: | | | | | | | | | | | |
| 9 | Health Health Health Other tr | 20a. Method of Dis | | rie | 20b. Pla | ce of Dispos | ition (Name of | Graw St. | , Deer Date | 20c. Location - | | | | |
| ě. | 0 = = 5 | | Cremation 3 5 Other (Specif | | ate | | atory or other pla | | 1/27/00 | D T | 1 | M.1 | | |
| Baltimore, | artmen ortant: injury | | uneral Service Licer | | I De | | rk Cemet | | 1/27/00 | Deer I | ark, | , Md. | | |
| ä | S OF S | 1 Bra | 10.10% | + | | | | uneral H | | | | | | |
| | | 23a. Part1, Enter | the distase, or com | plications that cau | sed the death. | Do not enter | the mode of dyi | ond St., | or respiretory e | d, Md. 2 | 1550 | Approximete | | |
| 8 | Physician | snock, or nea | art fellure. List only | one cause on eac | ications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ne cause on each line. Approximete Intervel Between Onset end Deeth | | | | | | | Intervel Between Onset end Deeth | | |
| /Medical | | Immediate Cause disease or condition | | | Respita | pitatory Failure | | | | | | 4 Days | | |
| | Examiner | resulting in death) | | a | Due to (or a | e to (or as a consequence of): | | | | | | | | |
| | P # E | | | b | Multiple Myeloma 2 Yrs.5 mo. | | | | | | | | | |
| 68760, filests be executed g physician and as the burial-transit | physician and s the burdal-transit | Sequentially list or if any, leading to in cause. Enter Und | onditions, mmediate enlying | | | Due to (or as a consequence of): nfluenza A | | | | | 4 Days | | | |
| | og physic as the b | Cause (Disease or that initiated event resulting in death) | S Last | C. Due to (or as e consequence of): | | | | | | | | | | |
| P.O. Box | d by the attendin letached for use Physician/N | | | d | | | | | | | 1 | | | |
| . E | S de de | Part It. Other signi | ficant conditions o | ontributing to deat | h but not resulti | ing in the und | derlying cause gh | 23b. Dld | 3b. Did tobacco usa contribute to the cause of death? | | | | | |
| <u>.</u> | requires thet the death cer- seen signed by the attandin hould be detached for use eted by Physician/N | | | | | | | | 10 | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | | |
| S) | ires the signe of be of | | | | | | | | 04-141- | No. of the last of | 245 W | ere autopsy tindings | | |
| Records, | | | | | | | | | perfe | an autopsy ormed? | av co | reliable prior to empletion of cause | | |
| e e | The law ate has begge 2 s | | | | | | | | 10 | Yes 2⊠No | | déath? □ Yas 2E3 No | | |
| - | idean: The li certificate ha rector, page 3 Be Com | 25. Was case refe | rred to medical | | | | | 26. Placa of Dea | | | - 11 | Tas ZL NO | | |
| > | s certificant director | axaminer? | TO HONO SECRETAR | Hospital: | etient 2 EF | R/Outpatient | 3 DOA OH | nor- | | | r (Specif | (v) | | |
| | orthia neral c | 27. Manner of Dea | | 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | | | | ,, | | | |
| | meth. | 1 🖾 Natural 2 🗌 Accident | 5 Pending investigation | | ii ijo. y | | 1 Yes 2 No | | | | | | | |
| <u>></u> | tal or Attanding P ra after deeth. el Director: After t led in by the funera Certification: | 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State) | | | | | | | | | per or Rural Route Number, | | | |
| | O SEPTION O | | | | | 2010 | | | | | | | | |
| | in 24 hours in 24 hours he Funer pletely fill edical | 29a. Certifier (Check only one) | | | s of examination | | | me, date and place opinion, deeth occu | | | | | | |
| | ithin of the office of the off | 29b. Signature and title of certifier 29d. Date signed | | | | | | | | | (Month, | Aonth, Day, Year) | | |
| | - 5 - 0 | Macho 7 12 D0055341 | | | | | | | | Jan. 23, 2000 | | | | |
| | 0 | 30. Name and add | ress of person who | completed cause | of death (Item 2 | 3a) (Type. P | | | | Juli 2 | , 2 | | | |
| | 8 | Naoko | Harry and the | | | | | Md. 2120 |) 1 | | | | | |
| | State | 31. Date filed (Mor | nth, Day, Year) | 32. Reg | iştrar's Signatur | re L | / | | - | | | | | |
| | Registrar | | JAN 28 | 2000 | Bancora | Ø. | Loan | 102/ | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

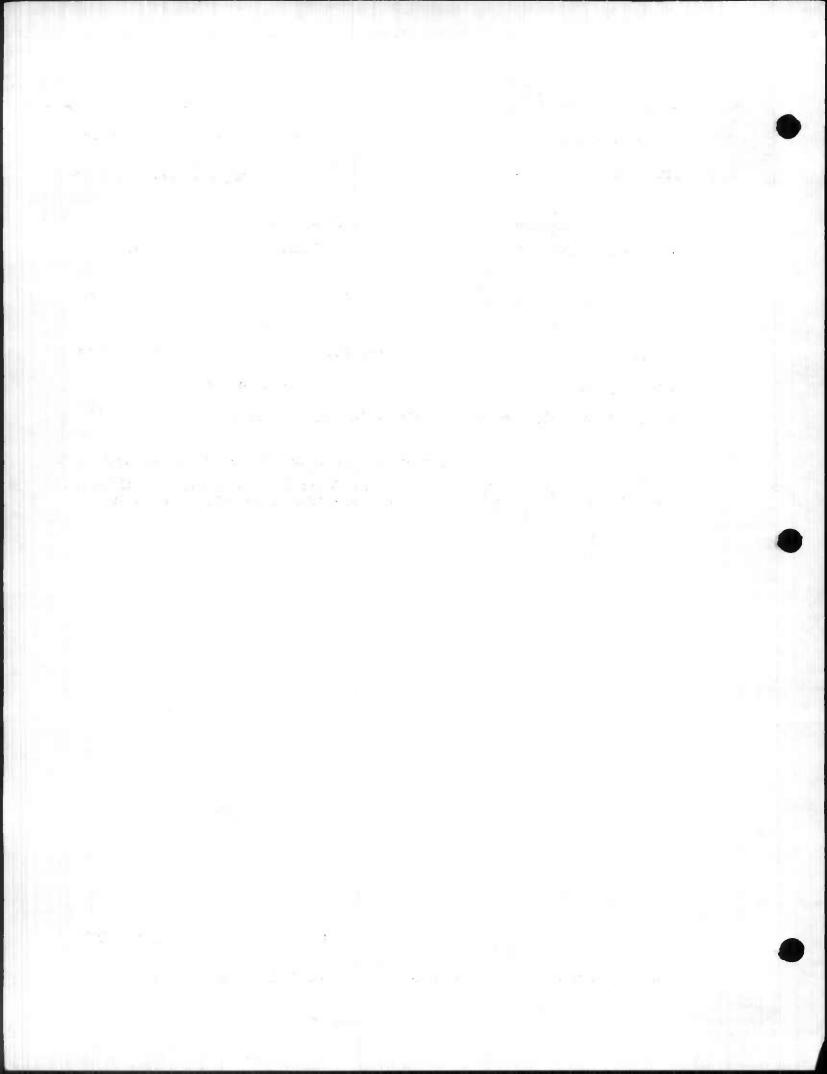
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** January 23, 2000 9:00 a.m. Delora Ellen Uphold /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Garrett Friendsville 49 Sang Run Road Hours Min 6. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□ M 2□ F Yrs. Director 218-16-2899 May 15, 1917 Maryland 82 Usual Residence of Deceden death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28a-f show the Medical Examiner must be notified at 1 Yes 2X No Director Friendsville MD Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21531 USA 49 Sang Run Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Meritel Stetus 14. Rece - American Indian Armed Forces Bleck, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Yeer or Detes: 1☑ Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White by 3 Widowed 4 Divorced "natural". Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event. Ithe Manage is the state of the st Eiementery/Secondery (0-12) College (1-4or 5+) Housekeeping 12th Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Laura Kellev George Uphold 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Co 1574 White Rock Rd., Friendsville, MD Delores June Sisler/neice 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Blooming Rose Cem., Jan.26, 2000 Friendsville, MD 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Newman Funeral Homes, P.A., 179 Miller St. Dumai P.O. Box 275, Grantsville, MD 23a. Part. Enter the Disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finei Arteriosclerotic Coronary Artery Disease Minutes disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. ed by the attending physician detached for use as the buria Physician/Medical Due to (or es e consequence of) P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to page 2 should Completed 24e. Wes en eutopsy performed? peen completion of cause of deeth? The law certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home SCXResidence 6 Other (Specify) 2 12 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and menner steted. completely (Check only one) 29b. Signeture apolititie of certifier 29d. Date signed (Month, Dey, Year) 29c. License number H 26154 Jan. 24, 2000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Paul Daniel Miller, D.O., 69 Wolf Acres Drive, Oakland, MD 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Registrar JAN 2 2000

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygie

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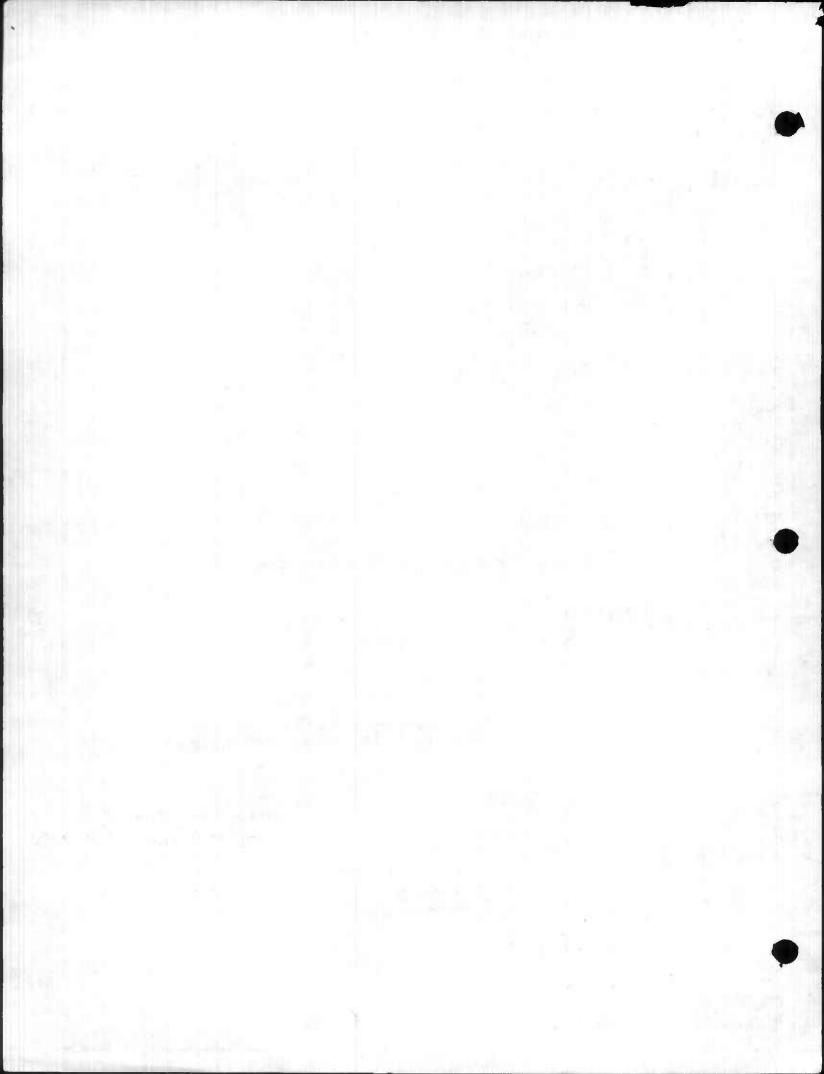
| EMY SCO | TT WILES | | (| Certificate of | Death | Re | g. No. | U | 1020 | | |
|--|---|--------------------------------------|---------------------|--|--|--|---|-----------------|----------------------------------|--|--|
| Dhysisian | 1. Decedent'a Name (First, Middle, La | (\$1) | | | | 2. Date of Deat Month | h Day | Year 3. | . Time of Death | | |
| Physician /Medical | Jeremy Scott Wile | | | | | JAN. 2 | 24, 2000 | | 1544 PM | | |
| Examiner | 4a Facility Name (If not institution, giv | | | | 4b. City, Town, or L | | 4c. County | | | | |
| | U.S. ROUTE#40 1 | | | | GRANT'SV I | | GARRE | | 10. 1 5 : | | |
| uneral rector | 5. Social Security Number 6. S 233-27-1277 Usual Rasidence of Decedent | Sex 7. Age 7. Age 18€ M 2□ F | (In yrs. last birth | Months Days | Hours Min. | 8. Date of Birth (Month, Day, July 31, | 1984 W | Country) | (State or Foreign | | |
| M 16 | 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. | Inside City Limits | | |
| ral Director | MD Gar | rett | | | Grantsvil | le | | | 1 Yas X No | | |
| lrec | 10e. Street and Number | | | 10f. Zip Code | | | Og. Citizen of W | hat Country? | | | |
| alD | 146 Bowser Lane | | | | 21536 | | U | JSA | | | |
| Funeral Director | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | rer in U,S. | 13. Was Decedent of If Yes, specify Cul | Hispanic Origin? (Sp ban, Mexican, Puerto | pecify Yes or No- Dican, etc.) | | - American I | ndian, | | |
| | 1 Never Married 2 Married | 1 ☐ Yes 2 🐼 No If Yes, Give | | 1 ☐ Yes 212 No | | | Specify: | | | | |
| d by | 3 Widowed 4 Divorced | Year or Dates: | 40.5 | | | | 10h Klad of Bu | Whi | | | |
| Be Completed | 15. Decedent'a E (Specify only highest gri | | 1 | Decedent's Usual Occu Give kind of work done life. DO NOT use retin | during most of work | king | 16b. Kind of Bu | siness/indust | ry | | |
| dwo | Elementary/Secondary (0-12) 8th | College (1-4or 5+ |) | 9th Grade | | | Norther | n High | School | | |
| ŭ | 17. Father's Neme (First, Middle, Last |) | | Jen Grade | | ne (First, Middle, I | | | . 5011001 | | |
| ToB | Teddy T. Wiles, J | r. | | | Sandra | Jean Arm | strong | Philli | ips | | |
| - | 19a. Informant's Name/Relationship (| Type, Print) | 19b. | Mailing Address (Stree | et and Number or Ru | ral Route Number | al Route Number, City or Town, State, Zip Code) | | | | |
| | Sandra J. Phillip | s/Mother | 146 | Bowser La | ane, Grant | sville, | MD 2153 | 36 | | | |
| | 20a. Method of Disposition | | 20b. Place of I | Disposition (Name of crematory or other plant | ace) | Date | 20c. Location - | City or Town, | State | | |
| | 12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | | Cemetery | | 2000 4 | ddison | PA | | | |
| d | 21. Signature of Funeral Service Lice | 900 | I | 22. Name and Addr | ress of Facility | | | | | | |
| 21 21 21 22 21 22 21 22 21 22 21 22 21 22 21 22 21 22 21 22 22 | 1 Juny | leumai | | Newman Fu | neral Hom | nes, P.A. | , 179 M | liller | St. | | |
| | P.O. Box 275, Grantsville, MD 2153 23a. Part. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or had fairn. List only one ceuse on each line. | | | | | | | | | | |
| n | shock, or notest tallure. List only one ceuse on each line. | | | | | | | | | | |
| t . | Immediate Cause (Final disease or condition Muttale Taisones | | | | | | | | | | |
| er | resulting in death) | D. D | e to (or as a co | onsequence of): | | | - 1 | | | | |
| edicai Examiner | | b | | | | | | 1 | | | |
| хаг | Sequentially list conditions, | D | ue to (or as a co | onsequence of): | | | | | | | |
| E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | C | | | | | | | | | |
| dic | that initiated events resulting in death) Last | D | ue to (or as a co | ensequence of): | | | | | | | |
| mark . | | d | | | | | | | | | |
| Physician/N | | | | | | L not Bullet | | | | | |
| Jys | Part II. Other significant conditions of | contributing to death but | not resulting in | the underlying cause g | Iven in Part I. | | es 2 No | | e cause of death | | |
| by Pt | | | | | 1.00 | 101 | 08 2LIN0 | 3 F100mb | d dominon | | |
| D D | | | | | | 24a. Wes a | n autopsy | 24b. Wera | autopsy findings ble prior to | | |
| Completed | | | | | | perfor | ned? | compl of dea | letion of cause ith? | | |
| E O | | | | | | 100/ | s 2 No | 1 X Y | | | |
| BeC | 25. Wes case referred to medical | | | | 26. Place of Dea | ith (Check only or | (0) | | | | |
| 0 | examiner? 1€37'es 2□ No | Hospital: | t 2 ER/Out | patient 3 DOA | | ome 5 Reside | | er (Specify) | AT SCENI | | |
| n: T | 27. Manner of Death | 28a. Date of Injury (Month, Day) | 28b. Ti | me of 28c. Inj | | 28d. Describe h | | | a a - d | | |
| atio | 1 Naturel 5 Pending 2 Naccident investigation | | 1 5 | | Yes 2 No | OK-LONILLY | 2 P2 N 30 | t you | is i for | | |
| Iffe | 3 Suicide 6 Could not be determined | | y - At home, fan | n, street, factory, office | 9 | 28f. Location (S. City or Town | treet and Numb | er or Rural R | oute Number, | | |
| Certification: | | US R+ 40 | | Cost of PA | Ine ! | Grants | 11 | MD | | | |
| S S | 29s. Certifier 1 Certifying Pr | nysician: To the best of | my knowledge, | deeth occurred et the | time, date and place | and due to the c | auco(s) and ma | nnar as state | id. A causa(s) | | |
| Medical Certifi | 1 | and manner state | ed. | Vor investigation, in my opinion, death occurred at the time, date and place, and di | | | | | | | |
| Σ | 29b. Signature and title of certifier | | | | nse number | 2 | 9d. Date signed | | | | |
| | 1 Tayon | -end | | C | C.M.E | | JAN. | 25, 20 | 000 | | |
| , | 30. Seme and address of person who | completed cause of dec | eth (Item 23a) (1 | ype, Print) | | | | | | | |
| | ACAKAN POL | KE, MO | 111 | Penn Street | et, Baltim | ore, Mar | yland 2 | 1201 | | | |
| State | 31, Date filed (Month, Day, Year) | 32. Registrar | 's Signeture | , , | | | | | | | |

DHMH 16 Rev 6/95

Registrar

JAN 2 7 2000

forth



State of Maryland / Department of Health and Mental Hygiene 04326 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1.30 PM 0 8 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 Milles al 8. Date of Birth Month, Day, Yearlog If Under 24 Hrs. Birthplacer (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 214-38-376 Hours 1□ M 20XF Yrs. Director arolino Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2 2 00 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 t. Maritai Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify. Specify P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. /DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Callege (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 1)0. 2 ne 19a Informant's Name/Reletionship (Type, Print/daughter-in 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) law 0, 20b. Place of Disposition (Neme of partietery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removel from State 12600 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Joseph W. Not AUR far the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart fasyre. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel week smal disease or condition resulting in death) Examiner Examiner 4 week attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) week sep ors Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence o() 208 been signed by the attershould be detached for Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebra 198CHUCH accider P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes Division of Vital Be 25. Wes case referred to medicel axaminer? 26. Place of Death (Check only one) Hospitel: 1□ Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Unpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 26a. Dete of tnjury (Month, Day Year) 28c. Injury et Work? or Attending Patter death. 5 Pending investigation Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hotpital of the the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end mannar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end fille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 2000 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Hadin 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

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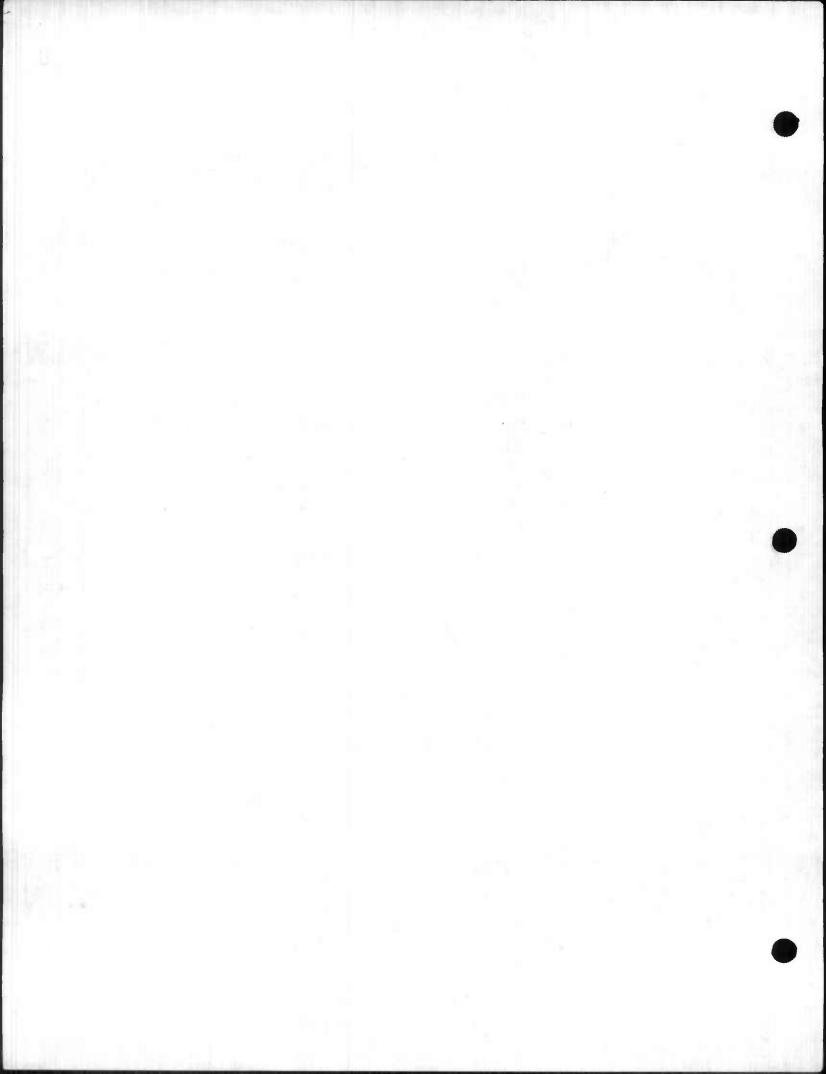
State of Maryland / Department of Health and Mental Hygiene 00 04327

| Physician | | | | | 001 | · · · · · · · · · · · · · · · · · · · | OI I | Death | | P | eg. No. | | |
|--|--|---|--|---|---|---------------------------------------|-------------------------------------|--|--------------------|--|--|---|--|
| Physician | 1. Decedent's Name (First, M | | | | | 1 | 2. Date of Dea | | M | 3. Time of De | | | |
| | Leon | R. | | | | | Bro | wn | | Month 2 | 6 2 | OOO | 6 42 8 |
| /Medical Examiner | 4a Facility Name (If not instit | | street and nun | nber) | | | - | | , or Loca | ation of Death | 4c. Count | y of Death | |
| Examiner | 3713 Sylvan | | | | | | | Balto | | | N/A | | |
| | 5. Sociel Security Number | 6. Se | _ | 7. Age (In yrs. I | aet hirthday) | If Under 1 | | If Under 24 | Hrs. | B. Dete of Birth | | 9 Rirthr | Naca (State or Fr |
| Funeral Director | 220-14-1654 | | M 20F | 79 | Yrs. | | Days | | Min. | (Month, Day | , Year) | Cour | place (Steta or Fo |
| JIIECTOI | Usual Residence of Deceden | it | | 13 | | | | | | 3-9-1 | 920 | | TN |
| E es | 10a. Stete 10b. Cou | | | 10c. City | , Town or Lo | cation | | | _ | | | 1 | I Od. Inside City L |
| 45 0 | Md | N/A | | Balti | mme | | | | | | | | 1 Xes 2 |
| be notified Director | 10e. Street and Number | | | 2000 | 11000 | 10f. Zip C | Pode . | | | | Og. Citizen of | What Core | nto O |
| | | | | | | | | | | | | | ntry r |
| nation of the state of the stat | 3713 Sylvan | nrive | | | | 212 | | | | USA pecify Yes or No- 14. Race - American Inc | | | |
| r Nems 23s siner.must Furneral | 11. Merital Status | | Armed For | dent Ever in U.S ces? | 5. 13. V | Wes Decede f Yes, specif | int of H y Cuba | ispanic Origin n, Mexican, P | 7 (Spec | ify Yes or No- ican, etc.) | | ce - Americ | |
| | 1 ☐ Never Married 2 ☐ I | | 1 Yes | 2 □ No | 1 | 1 Yes 2] | KI No | Specify: | | | Specil | V: D1- | - ala |
| Exa d by | 3 Widowed 4 Divor | rced | Yeer or De | etes: | | | | | | | | y: Bla | ICK |
| yglere. Ner than "naturn rt, the Medical. Completed | 15. Dece (Specify only hi | dent's Edu | | | 16a. Deced | dent's Usuet kind of work | Occupa | ation Jurina most of | working | , | 16b. Kind of B | lusiness/In | dustry |
| ab Cha | Elementery/Secondery (0-1 | | College (1 | -4or 5+) | life. L | DO NOT use | retired | luring most of) | | | Afro | Amer | ican |
| Con the | 12th grade | | 2 year | S | P | rinter | | | | | New | spape | er |
| | 17. Father's Name (First, Middle, Last) | | | | | | | | | | Maiden Sumei | me) - | |
| Menta srkad srice To E | Arnold Bro | wn | | | | | | Zad | ie B | Brown | | | |
| Dur | 19e. Informent's Neme/Relet | lonship (T) | ype, Print) | | 19b. Meilin | ng Address (| Street | and Number o | or Rural | Route Numbe | r, City or Town | , State, Zir | Code) |
| 27 tr | Johnnie D. | Brow | n-Wife | | 371 | 3 Sylv | van | Drive | В | altimor | e, Md | 2120 | 7 |
| E # 46 | 20e. Method of Disposition | | | 20b. Pl | ece of Dispos | sition (Neme | of of | a) | | Date | 20c. Location | - City or To | own, Stata |
| 100 | 15 Suriel 2 Cremati | | | | cemetery, cremetory or other plece) | | | | | | Owing | s Mil | ls, Md |
| nitra | 4 □Donetion 5 □Othe 21. Signeture of Fupperel Sen | | | | | . Neme end | | | | 2-15-00 Owings Mills, Md | | | |
| my in | 21. Signeture of Fundret Serv | ice cicers | 11. | | | | | | | | | | 21215 |
| | 1/ vala | / | are | ch | 111 | iar Cili | e / n | West | 4 | 300 W | abash | Ave | Balto, |
| physician and is the burlet-transit edical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events | 1 | b | | as a conseq | | | | | | | 1 | |
| £ # # | | | | Due to (or | as e conseq | uence of): | | | | | | 1 | |
| nding use s | resulting in death) Last | L. | d | | | | | | | | | t | |
| nding use s | resulting in death) Last | ditiona cor | d | ath but not resu | lting to the ur | nderlying cau | ise oiv | an in Pert I | | 23b. Did to | phaceo usa er | ontribute t | o the cause of d |
| by the attending ached for use a hysician/M | resulting in death) Last Part It. Other algorificant con- | ditiona con | d | ath but not resu | iting to the ur | nderlying cau | use giv | en in Pert I. | | | | | o the cause of d |
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| certificate has been signed by the attending itector, page 2 should be detached for use a sector, page 2 should be detached for use a Be Completed by Physician/M | Part tt. Other algnificant cond 25. Wes case referred to med axaminer? | dical | Hospitet | | | | Oth | 26. Place of | | 24a. Was e perfor | n eutopsy med? | 3 Pro | bably 4 Uniter autopsy finditional deprivation of the substitution |
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Maria San

State of Maryland / Department of Health and Mental Hygiene 00 04328

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| | 2 | Oe. Street and Number 3828 Beehler 1. Meritel Stetus | | | D - 71-2 | Town or Lo | ocation | | | | | | 10 | d. Inside City Limits |
| | 2 | 3828 Beehler 1. Meritel Stetus | Avenue | 10e. Street and Number 10f. Zip Code 21215 | | | | | | | | a. Citizen of V | 10-10-1 | 1 Xes 2□No |
| | 2 | | | 9 | | | | | | | 10 | | A A | ny r |
| 24 9 | 2 - | 3 Widowed 4 Divorce | orried Am | s Decedent ned Forces? Yes 2 1 1 es, Give ar or Detes: | | | If Yes, sp | ecify Cubi | lispenic Ori an, Mexicen Specify: | gin? (Spec , Puerto R | ify Yes or No- icen, etc.) | | e - America k, White, e | etc. |
| 7 4 7 | | 15. Decede (Specify only high | nt's Education | (lotad) | | 16a. Deced | dent's Us | ual Occup | ation during mos | t of working | | 6b. Kind of Bu | | |
| if, the Medical I | | Elementery/Secondery (0-12) 5th grade | 1 | lege (1-4or 5 N/A | 5+) | life. I | DO NOT | use retired | vemer | | | City | Of | Baltimore |
| No se | D 1 | 7. Father's Name (First, Middle | , Last) Un | k | | | | | | | (First, Middle, M | le <i>id</i> en Sumam | e) Unk | |
| aumatic T | | 19a. Informent's Neme/Reletion | ship (Type, Pri | nt) | | | | | | | Route Number, | | | |
| er tr | | Helen Outte | n- Nie | ce | | | | | ler A | Aveni | ie Ba | Itimor | ce, Mc | 21215 |
| | 2 | 0a. Method of Disposition ¶☐ Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (| | I from Stete | cerr | ce of Disponerery, crem | metory or | other plea | eterar | 2- | Dete 2 | Owing: | | um, State Ls, Md |
| Important: any injury once. | 2 | 21. Signeture of Funerel Service | Licensies | L | and | | March | n F/ | ss of Fecilit | st | | | | |
| | + | 23a. Part1. Enter the disease, | or complications | that causer | the death | Do not ent | 4300 | Wal | oash | Aven | ue Balt | imore, | Md | 21215 Approximete |
| sician edical aminer | 10 | shock, or heart feilure. Li Immediate Cause (Finet disease or condition resulting in death) | st only one ceus | | ASPIA | 2Ano | ั้ม | PA | 16110 | NA | | | | Intervel Between Onset and Death |
| 2 | 5 | West A | | | Due to (or a | | |): | | | .0.0.1 | | | |
| nsit all | | | b | | CEI | C WH | O WI | 4500 | LAR | A | CIVEN | | 11 | 5 9 EASES |
| use as the burial-transit | T T | Sequentially list conditions, if ony, leading to immediate susse. Enter Undertying Cause (Disease or injury hat initiated events resulting in death) Last | c | | Due to (or a | S a conseq | TLY (| 760 | | ACTE | coil Cal | ws | | 10 y Cores |
| letached for use | P | Pert II. Other significant condi | Ions contributin | g to death b | ut not resulti | ing in the u | inderlying | ceuse giv | en in Pert I | | 23b. Did tol | bacco uas co | ntribute to | the causs of death? |
| signed by the attending p d be detached for use as | | -PROSTATE | CAM | CER | • | | | | | | 1 🗆 Ya | 8 2□ No | 3 Prob | bebly Unknown |
| shoul | | - ABDOMEN | IAT | ADR | nè, | ANGU | rys | 7 | | | 24e. Wes ar perform | | ava | ora autopsy findings nilable prior to npletion of ceuse death? |
| director, page 2 | | - LUNG | TUM | of | | | | | | | 1 □ Ye | s 2 10 | 1 [| Yes 2 No |
| ctor, | 2 | 25. Wes cese referred to medic | al | | | | | | 26. Plece | of Death | (Check only one | 9) | | |
| 00 | 2 | axaminer? 1 Yes 2 No 7. Manner of Death 1 Naturat 5 Pend | Hospitel 28a. | 1 ☐ Inpatie Dete of Inju (Month, Da | | R/Outpatier 8b. Time of Injury | ıt | 28c. Injur | y at | 2 | e 5 Reside 8d. Describe ho | | | 1) |
| To the Funeral Director: After thi completely filled in by the funeral Medical Certification: | | 3 Suicide 6 □ Coul | tigation d not be mined 28e. | Plece of Inj | ury - At hom c. (Specify) | e, farm, str | M reet, facto | | Yes 2 | | 8t. Location (Stu City or Town | | er or Rura | l Route Number, |
| To the Funeral Director: completely filled in by the Medical Certifical | | (Check only 2 Medica | Examiner: On | the basis of | examination | | | | | | nd due to the ce | | | |
| Med Med | | one) 29b. Signature and title-of certif | | d manner ste | ered. | | 25 | 9c. Licens | e number | 1// | 29 | d. Date signe | d (Month. | Day, Year) |
| = 8 | - | ▶ l.led | | | | | 260 | 3 | | | | | | |
| XI | 3 | 0. Name and address of person | n who complete | | leath (Item 2 | | | ANCH | 01 | GU | EN Pare | NiE + | 1d | 21060 |
| State | 3 | 31. Date filed (Month, Day, Yea | 7) | | er d Signatur | | 9 | | 150 | | ·OV K | ~/6 | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year **Physician** Gertrude 12:27 P Bean February 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimor Ba Hi | Funder 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 215-30-6026 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Batimore 1 Yes 2 No Md NA Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21215 23/8 U.S.A Park 238 rug Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried Black b 1 Yes 2 No Specify: à 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Thypiens. Other than "n Jamuel Elementery/Secondary (0-12) College (1-4or 5+) 00K Kandolph tth grayle NA permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Briscoe William 19a, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurat Route Number, City or Town, Stete, Zip Code) Hert Bean Balto, Med 21215 in wood ive 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cometery, cremetory or other p Dete 20c. Location - City or Town, Stete enetery 4 ☐ Donation 5 ☐ Other (Specify) Lion 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility 2/2/3 svenue Balto nit Wabash 1300 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final 3 0075 Sepsis disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Due to (or as a consequence of): signed by the attending to be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yea 2 No 3 Probably 4 Unknown Anemia þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 No certificate 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined

or Attending Physician: The law requires that the death certificate be anacuted Box 68760. P.O. Division of Vitai Records,

Maryland

72 hours after

21215-0020

Maryland

Baltimore,

After this filled in by

ie Hospital or Attending n 24 hours after deeth. ne Funerel Director: Afti To the Hosp within 24 hor To the Fune completely fi

Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number RES-000

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Dey, Year) 9,2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Sina: Hospital of Baltimer Brown MO Justan

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

29b. Signatury and title of certifier

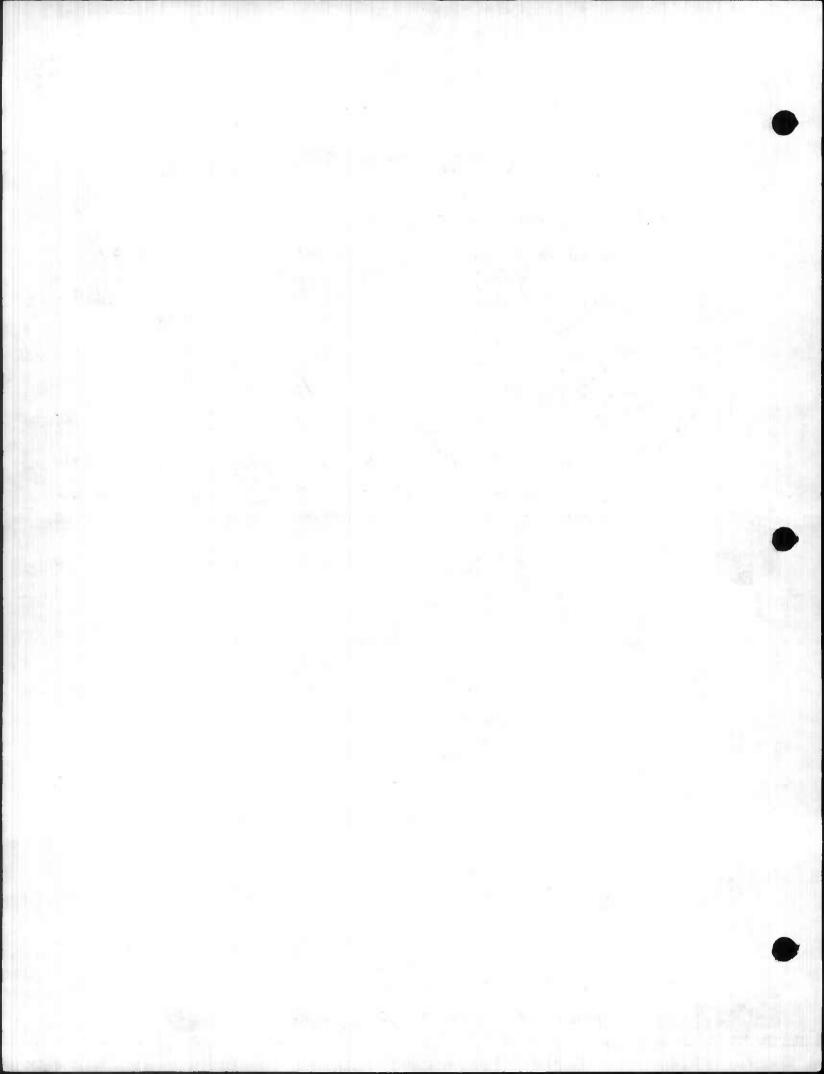
3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registraris Signature 4 2000 ▶ FEB 1



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death BARNET Day Le D'Mary & Cu-Month **Physician** FRANK 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** H Under 24 Hrs +, more INIS N/A 10000 If Linder 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 15M 20 F Yrs. 420-28-5615 Director ALABAMA **Usuat Residence of Decedent** the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 K No Director WALKER DORA 28a-f 10f. Zip Code 10e Street and Number 10o. Citizen of What Country? 8 238 35062 5319 GREATHOUSE ROAD Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. Armed Forces 1
1 XYes 2 No WII & Yes, Give WWII & Year or Dates: Korean filed within 72 hours after 1 Never Married 2 ☐ Merried 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced WHITE Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 8TH GRADE College (1-4or 5+) TELEPHONE PBX INSTALLER-REPAIRMAN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H ant: If Nem 27 is marked off jury or other traumatic even KIMZY J. BARNETT HATTIE BUSBIN 19e. fnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LT. COL. FRANK W. BARNETT, JR. 6105 DOMINICAN DR. SPRINGFIELD, VA 22152 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burlal 2 Cremation 3 Removal from Stete 2/12/2000 4 ☐ Donation 5 ☐ Other (Specify) NEW HORIZON MEM. GAR. DORA, ALABAMA 21. Signature of Euperal Service Licenses 22. Name end Address of Fecility THE JOHNSON FUNERAL INCID., 2....

8521 LOCH RAVEN BLVD. TOWSON, MD 21286
Approximate Interval Between Onset and Death or complications that caused the deeth. Do not ente Physician 4 MONTHS /Medical Immediata Cause (Finat METASTATIC LUNG CANCER disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of) esn Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? P.0. Probably 4 Unknown 1 ☐ Yaa 2 ☐ No ARTERY DISEASE Division of Vital Records, þ 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Completed ASBESTOS HYPERTENSION completion of cause of death? 20 No 1 Yes 2 No or Attending Physician: funeral director, 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Yes 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To the threatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Naturat 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

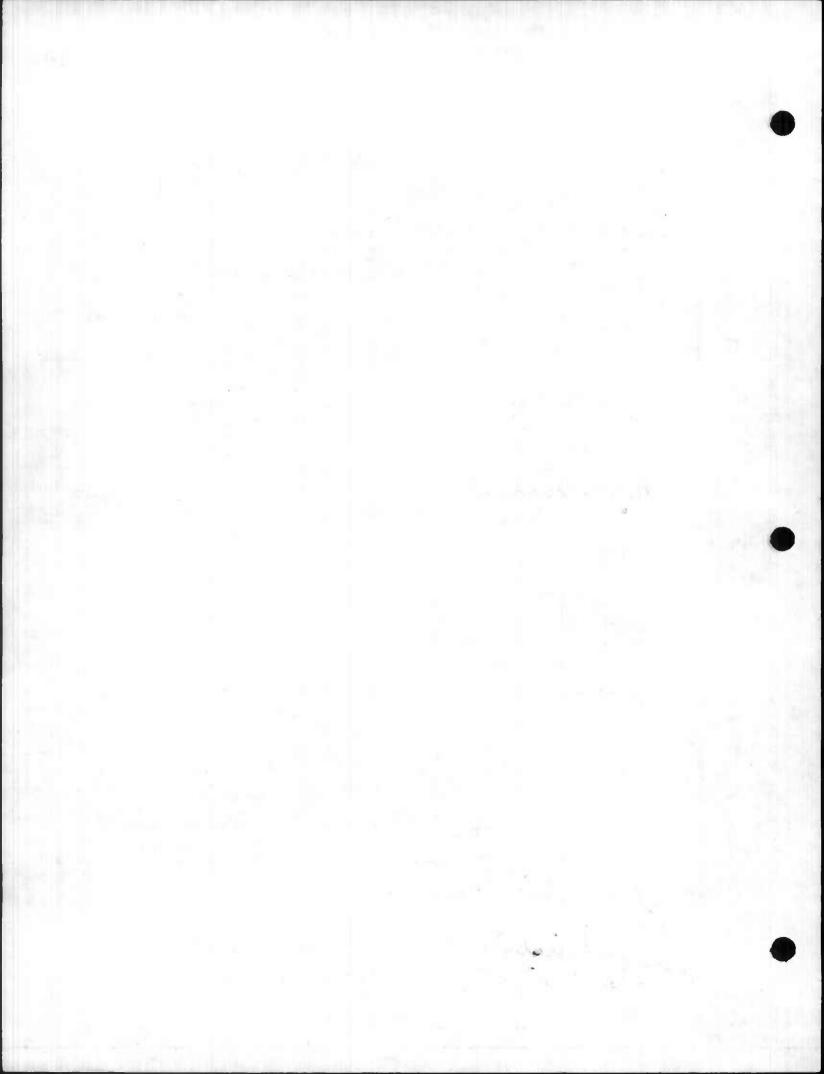
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MO RES-000 FEBRUARY 8, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 0 JOHNS HOPKINS HOSPITAL BALTIMORE, MO 21205 ROTHMAN, M.D. 31. Date filed (Month, Dey, Year) FEB 1 4 2 32. Registrar's Signature State 2000 Registrar



DHMH 16 Rev 6/95

Registrar

FEB 1 4 2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Fobruary 10 av Rozalla 70 Sca 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth charlestour If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Certer)are Baltimore 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) Months Days 10 M 2/0 F Yrs. 213-20-3358 91 Dec. 1, 1908 Balto. Co. Md Usual Rasidance of Dacedani 10a Stete 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Md. Baltimore Reisterstown 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 21136 USA 107 Fitz Court 12. Was Dacedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Orlgln? (Spacify Yes or No-If Yas, specify Cuben, Maxicen, Puerto Rican, atc.) 11. Marital Status Race - American Indian, Bleck, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify: 3 Widowad 4 Divorced White 15. Decedent's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Secretary Balto. Co. Goverment 12th Grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Harry F. Arbaugh Carey V. Comely 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) June Byrd Brown (Daughter) 117 Links of Leith, Williamsburg, Va. 23188 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, Steta 1 Durial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) Carrollton Church of God2/17/00 Finksburg, Md. 21. Signature of Funaral Service-Licensee 22. Name end Addrass of Fecility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 tene Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition rasulting in death) . Renal cell carcinoma Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadieta ceuse. Entar Underlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 🗆 Yas 2 No 25. Was cesa rafarred to medice axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding Investigation 1 Natural 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homleida

Examiner The law requires that the death certificate be executed attending physician for use es the bune the signed by the a been signature Completed certificate has b director, page 2 sl uneral director. Be 2 this Certification: After ector: A

Physician/Medicai

þ

Physician

/Medical

Examiner

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

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Funeral

Completed by

Be

2

7 is marked other than "naturel", or items 23s or 28s-f ebov traumstic event, the Modical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death with it Department of Heelth and Mental Hygiene. Important: If from 27 is marked other than "nature!" — any injury or other traumatic events.

the Maryland

Box 68760, Division of Vital Records, P.O. Attending Physician: death. à efter I Dire

ö

Name:

0 Registrar

State

filled in t

Medicai

To the Hospital o within 24 hours of To the Funeral Di completely filled i

31. Data filed (Month, Day, Year) FEB 1 4 2000

(Check only

29b. Signatura and title of certifier

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) Maiden Choice

29c. Licansa number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner es stated.

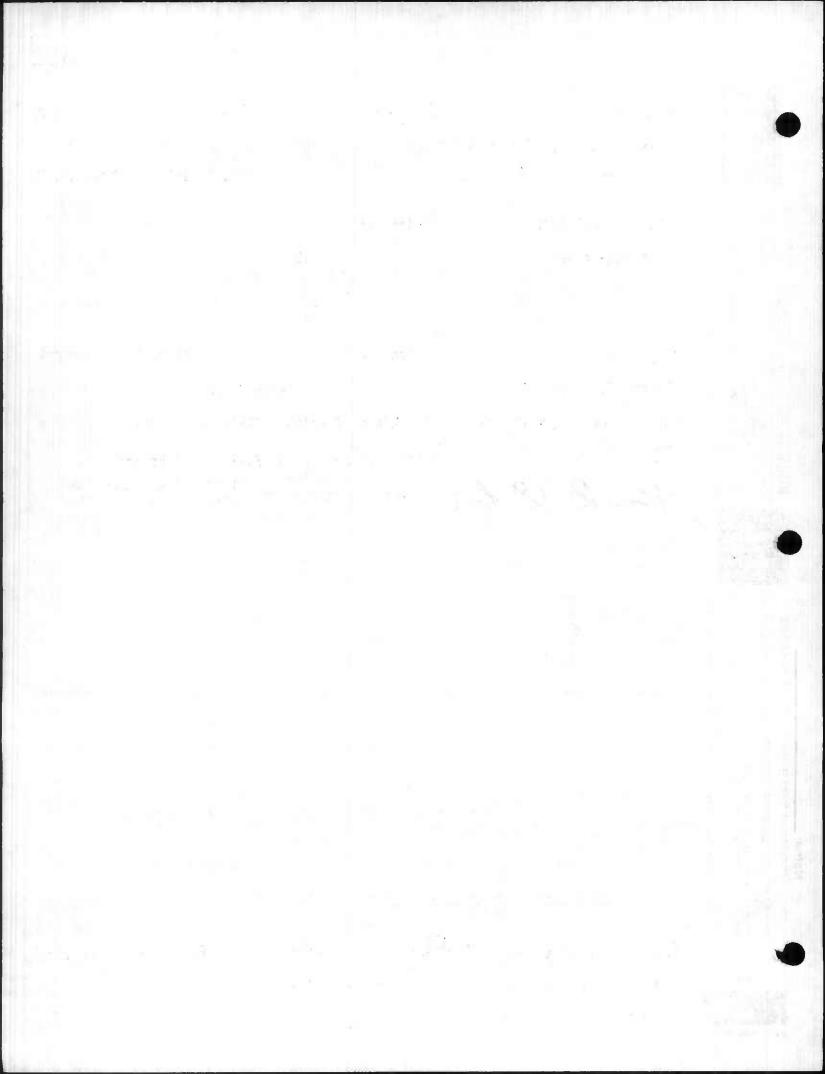
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29d. Date signed (Month, Day, Yeer)

2003

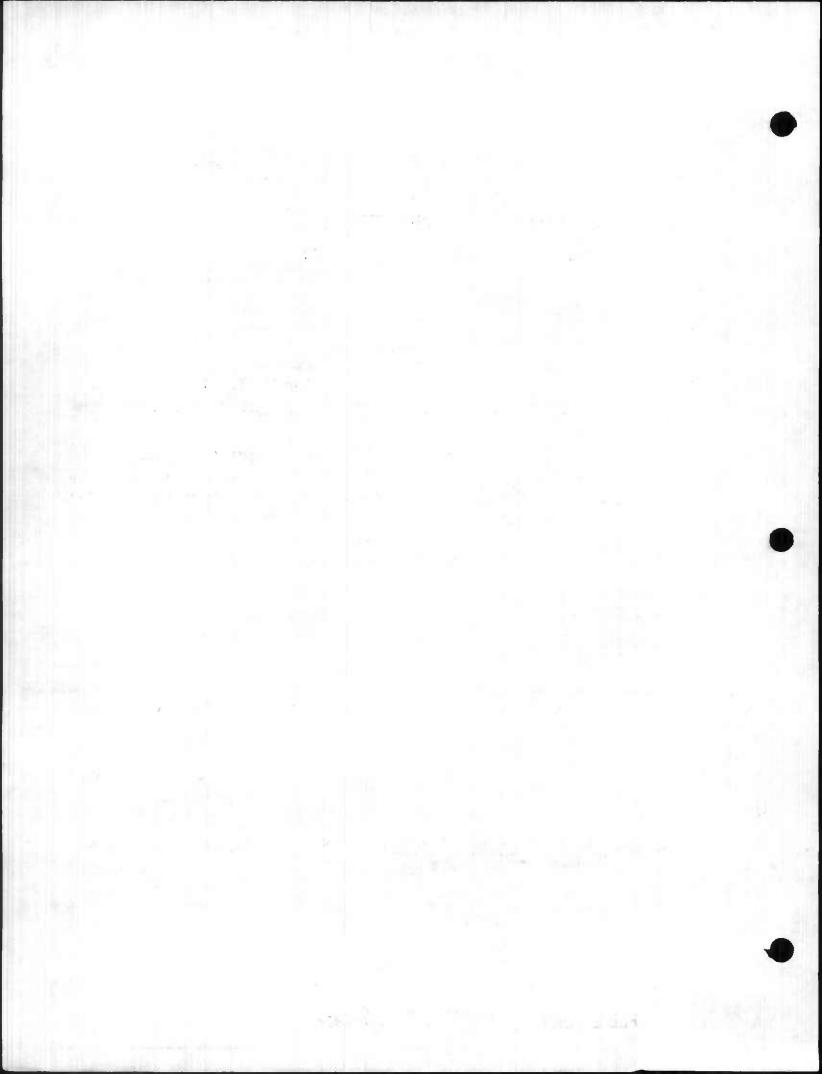
In Catorsville

33 Registrar's Signatura

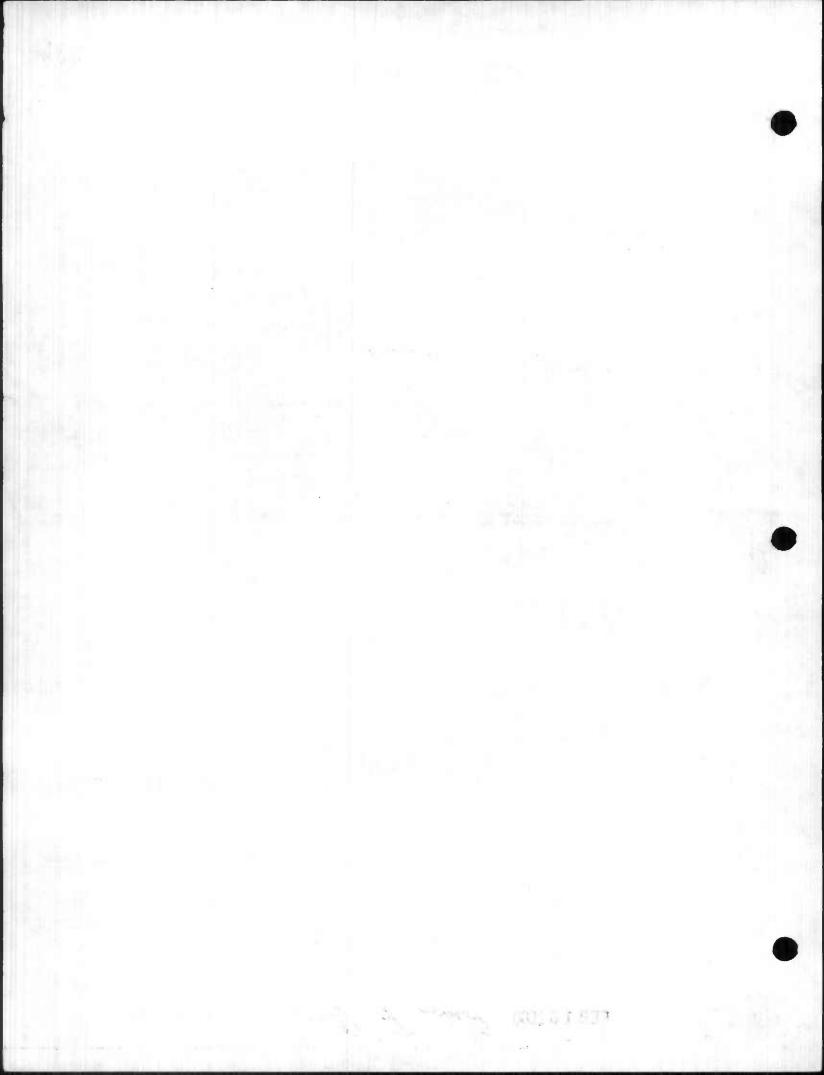


State of Maryland / Department of Health and Mental Hygiene

| | Physicia | | Decedent's Neme (First, Middle, Donald Leroy | | | Certi | ficate of | Death | 2. Date of D | Day | Year | Time of Death | |
|----------------------------|---|--|---|---|-------------------|--|-----------------------------------|--|---------------------------|--|---------------------------|---|--|
| | /Medica Examine | | 4e Facility Neme (If not institution, g SINAI HOSPITAL | | er) | | | 4b. City, Town, or BALTIMOR | | | | 1619 PM | |
| | Funeral Director | | 213-46-1131 | Sex 10AM 20F | Age (In yrs 52 | A A | f Under 1 Year Months Days | If Under 24 Hrs Hours Min. | 8. Date of B (Month, I | irth (Pear) 1947 | 9. Birthplace Country) | (State or Foreign | |
| | yland | | Usual Residence of Decedent 10e. Stete 10b. County | | 10c. C | ty, Town or Local | lion | | | | | Inside City Limits | |
| | Ba-f si | C10 | MD Baltir | nore | | Pikesvi | lle | | | | | 1 Yes 2 No | |
| | VIT TO 10 | 212 | 10e. Street and Number | | | | 10f. Zip Code | 1000 | | 10g. Citizen of V | | | |
| | eath v | Funeral Director | 16 Dreher Ave. | 12. Wes Deceder | at Ever in I | IS 13 Wa | | 21208 | Inacify Yes or N | USA to 14 Bac | e - American I | Indian | |
| 020 | E S. | 2 | 1 Never Merried 2 X Merried 3 Widowed 4 Divorced | Armed Force | s?] No | | es, specify Cub | lispanic Origin? (S an, Mexican, Puer Specily: | to Rican, etc.) | Specify Specify | k, White, etc. | | |
| 5-0 | 72 hc | Completed | 15. Decedent's (Specify only highest (| | | (Give kin | t's Usual Occup d of work done | during most of wo | rking | 16b. Kind of Bu | usiness/Indust | ry | |
| 121 | within then | E C | Elementery/Secondery (0-12) | College (1-4o | r 5+) | | NOT use retired | • | | Solf E | mploye | d | |
| 9 | Hygid other | e e | 17. Fether's Neme (First, Middle, La | st) | | Truci | DITTE | | me (First, Midd | le, Maiden Suman | | 4 | |
| /lar | Mental Mental arked o | 0 | Unknown | | | | | Loretta | F. Bul | 1 | | | |
| , Maryland 21215-0020 | and and le man | | 19e. Informent's Neme/Reletionship Sharon Ann Bul | | | 16 Dreh | ner Åve. | and Number or Ri ,Pikesvi | ille, MI | ber, City or Town, 21208 | State, Zip Co. | de) | |
| altimore, | Pa ant: | | 20e. Method of Disposition 1 KBurial 2 Cremetion 3 4 Donetion 5 Other (Special Control of Control | | 9 | Place of Dispositi cemetery, cremat 1e Grove | ory or other place | | 2/14/00 | Rayvill | | State | |
| Balt | pemit. Pa Departmen Important: any Injury pncs. | | 21. Signature of Funerel Service Lic | ensee | ni. | 100 | ine Fund | ss of Facility | | Reister terstown, | stown | Rd 21136 | |
| | Physician /Medical Examiner | Je. | 23a. Per 1. Enter the disease, or co shock, or heart failure. List on tmmediate Cause (Final disease or condition resulting in death) | mplications that caus ly one cause on each a. | Mu | | INJUR | | c or respiratory | arrest, | int | proximate erval Between eset and Death | |
| x 68760, | 5 0 6 . | 2 | Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in deeth) Last | c | | or as a consequen | | | 1 | | 1 | | |
| Bo | d for us | LCIBIL | Dort II Other elgolificant conditions | contributing to doubt | but not re- | rulting in the unde | thing sound six | on in Bart I | 225 DI | d tobecco use co | ntellucto to th | a course of death! | |
| , P.O. Box | ires that the death cert signed by the attendin d be detached for use | Dy Physicianym | Pert II. Other algorificant conditions | contributing to death | Dut Not 19: | suring in the unite | arrying cause go | en al Part I. | | Yes 2 No | | ly 4 Unknow | |
| ecords | aw requisite to should be | pajaiduion | | | | | | | | is an eutopsy formed? | availal | autopsy findings ble prior to etion of cause th? | |
| <u> </u> | ata h | 5 | | | | | | | 15 | Yes 2□No | 1)2 Y | es 2 No | |
| Ž | Certific | | 25. Was case referred to medical examiner? | Hospitet: | | N# 4 | off post Off | 26. Place of De | | | | | |
| ō | | | \$CXYes 2☐ No 27. Manner of Death | 28a. Date of In | jury | 28b. Time of | 3 DOA 28c. Injur | 4 LI Nursing F | 1 | sidence 6 DOth how injury occur | | | |
| Division of Vital Records, | To the Hospital or Attending Physicien: Within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director, | Cer uncauon. | 1 Naturai 5 Pending 22 Accident 3 Suicide 6 Could not 4 Homicide determine | be 28e Page of I | niury - At h | injury 3:36 P ome, ferm, street outside | M 1)K | k? Yes 2□No | 20f Lanation | RAN OVER E (Street and Numb own, State) (L | or or Dured D | outo Alumbar | |
| | To the Hospital within 24 hours of To the Funeral completely filled | 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. | | | | | | | | | | | |
| | To the To the Comp | M | 29b. Signature and title of certifier | 1. The | | 20.1 | | e number ME | | 29d. Date signe FEBRUAR | | | |
| | State | | 30. Name end address of berson what TACK W. TACK 31. Dete filed (Month, Day, Year) | s, M.D. | | 1 Penn S | | Baltimor | re, Mary | rland 212 | 201 | | |



| ysician | | na (First, Middle, Las BARBARA | 780 2/16/0 st) | | | tificate of | Dealli | 2. Date of Do Month FEBRUA | Day | Year | Time of Death : 19P.M. |
|---------------------------------------|--|---|---|-----------------------------|--------------------------------|--|---|------------------------------------|--|---|------------------------|
| Medical aminer eral | | MORIAL HO | | e (in yrs. lest | | If Under 1 Year Months Days | | Location of Deat | th 4c. County | of Death | State or Foreign |
| ctor | Usual Residence of | 10b. County | | 10c. City, T | | cation | | MAK. Z | 0, 1932 | | MD side City Limits |
| must be notified at leral Director | MD 10e. Street and Nu | mber LET HILL I | 2010 #202 | BA | ALTIM | 10f. Zip Code | 1210 | | 10g. Citizen of V | What Country? | Yes 2 No |
| by Funeral | 11. Marital Stetus | ried 2 Merried | 12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | | | | 1210 Hispanic Origin? (Stan, Mexican, Puerl | pecify Yes or No o Rican, etc.) | U.S.A o- 14. Rac Blac Specify | e - American Inc ck, White, etc. | |
| Completed | (Spe | 15. Decedent's Ed | lucation | | (Give | lent's Usual Occu kind of work done OO NOT use retin | during most of wor | king | 16b. Kind of B | usiness/Industry | |
| Be | | (First, Middle, Last) | 2 | H | IOMEM. | | | ne (First, Middle | OWN HON | ne) | , |
| To | 19e. Informent's N | ION Ieme/Raletionship (1 EBERMAN / | | 1 | | g Address (Stree | ROSE of and Number or Ru OAD - BAL | | | | |
| | | | Removel from State | СВІТН | etery, crem | sition (Name of natory or other pla CIRCLE C | | Date 2/11/00 | | City or Town, S | |
| | 21. Signeture of F | uneral Service Licen | 500 | | | Name and Addr | ess of Facility SC TERSTOWN | | SON & BE | | |
| Physician/Medical Examiner | Immediate Cause diseasa or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that indicated event resulting in death) | onditlans, mmediate artying r injury | b | DRUG I) Due to (or as | a conseq | uence of): | | | | | |
| | Pert II. Other algni | ficent conditions co | ontributing to death be | ıt not resultin | g in the ur | derlying cause g | iven in Part I. | | l tobacco use co Yes 2□ No | atribute to the | |
| Completed by | | | | | | | | | s an autopsy formed? | available | ion of cause |
| Be Com | 25. Wes case refe axaminar? | rred to medical | | | | | 26. Place of Dea | - | d∕es 2□No | 1 [7-40s | |
| Certification: To | 1 X Yes 2 C 27. Menner of Dee 1 Netural 2 Accident 3 X Suicide 4 Homicide | 140 | 2/0/00 | Year) EO | b. Time of Injury UNG 4: | P 28c. Inju | ary at ork?] Yes 2 [x]No | 28d. Describe subjec | took C | red lrugs per or Rural Rou 1 Hamle | |
| edical C | 29e. Certifier (Check only one) | | reician: To the best of iner: On the basis of and manner sta | f my knowled examination | dge, death | | | | cause(s) and me | | |
| Medical Certification: | 29b. Signeture and | misha | www.completed cause of de | | ia) (Type, I | O.C. | M.E. | | | d (Month, Day, Y 9, 2000 | |
| | Dennis | J. Chu | to no | | | 111 Penr | n Street, | Baltim | ore, Mar | yland 2 | 1201 |



00-0712-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygienen Ronald Brown amend item 23a, ptII, 27 per me 3/27/00 yg G781 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 07, 2000 2:15 P.M. RONALD WARREN BROWN, SR 4a Facility Name (If not institution, give street end number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 West 20th Street, Apartment 18P Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 GM 2□ F Months 217-36-2602 Yrs. Director 59 Mar 9, 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Example must be notified at 1 √ Yes 2 No Directo Maryland N/A Baltimore City 10a. Street and Number 10g. Citizen of What Country? 20th Street, 18P 21218 USA Funeral 11 W. 12. Was Decedent Ever in U.S.
Armed Forces?

1 Xes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Plumber 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hyant II from 27 is marked oth jury or other traumatic even Be 2 Joseph Edward Brown, Sr. Francis Elizabeth Earp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3408 Colonial Court, Olney, MD 20832

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date

Date

20c. Location - City or Town, State Joseph M. Brown (Brother)
20a. Method of Disposition permit. Pages Department of H Important: If No any Injury or of 2009. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Significant of Funeral Section See Druid Ridge Cemetery
22. Name and Address of Fecility 2/10/2000 Baltimore, Maryland Martin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate shock, or heart feiture. List only one cause on each line. Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ATHEROSCIEROTTC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): PO Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 32 Probably 4 Unknown ALCOHOLISM Records, þ Completed 24a. Was en autopsy performed? Limited page 2 s 1€ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this .27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: or Attanding P 5 Pending investigation 1XXVatural 1 Yes 2 No Director: / 2 Accident 3

Division of Vital To the Hospital o within 24 hours aft To the Funeral Di completely filled in

24b. Were autopsy findings available prior to completion of cause of death? 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

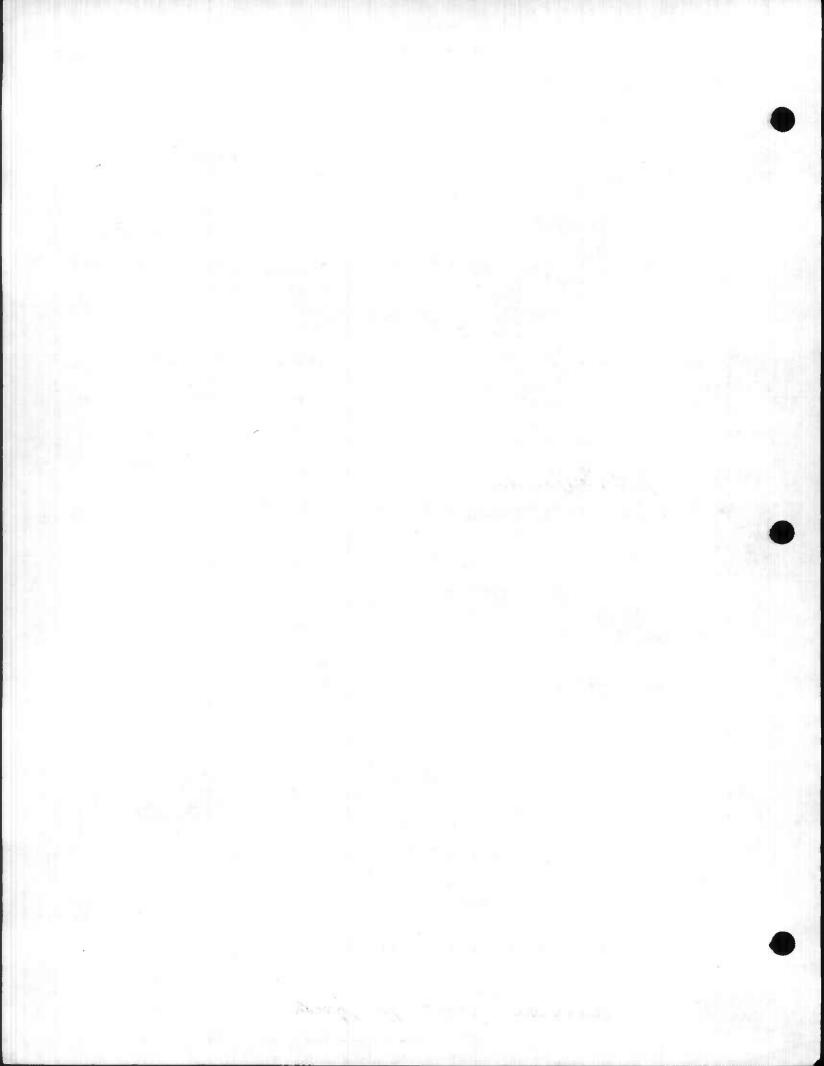
Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified O.C.M.E. February 08, 2000

30. Name and address of person who completed cause of death (fluor 200) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Strphen 5.
31. Date filed (Month, Dey, Year) 5. Radentz

State Registrar

32. Registrar's Signature Gener FEB 1 4 2000



Physician DITMAR BICK /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Center Franklin 5. Social Security Number Square Hospital (In yrs. lest birthday) **Funeral** Days Hours 64 Months 1⊠M 2□ F Director 216-32-9815 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location man be notified at Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 6303 Moyer Avenue 21206 Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene, important: if item 27 is marked other than "natural", or Nems any injury or other traumatic avant, the Manicelle. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 57 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown electrician 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumeme) Be Max Bick 19a. Informant's Name/Reletionship (Type, Print) Erika Bick/spouse

1. Decedent's Name (First, Middle, Last)

Frieda Neubert 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6303 Moyer Ave Baltimore, MD 21206 Date 20c. Location - City or Town, State

2. Date of Death

February

a/e Ba s. 8. Date of Birth Applicant, 10ay, Month

Day

Year

2000

Baltimore

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

white

Black, White, etc.

USA

Specify:

16b. Kind of Business/Industry

maintanence

21. Signature of Funeral Service Licansee
Joseph B. Van Sant 6 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1 Burial 2 Cremation 3 Removal from State

4 ☑ Donetion 5 ☐ Other (Specify)

22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Immediate Cause (Final disease or condition resulting in death)

Physician /Medical

Examiner

physician and the burial-transit

signed bed

should

page 2

After this

n 24 hours after death he Funeral Director: A pletely filled in by the f

To the Hosp within 24 ho To the Fune completely fi

death.

Hospital

The law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital or Attanding Physician: Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

20a. Method of Disposition

· Congestive Heart Failure Due to (or as a consequence of):

20b. Placa of Disposition (Neme of

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign Germany

10d. Inside City Limits

1X Yes 2 □ No

12:00 P.M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pulmonary Hypertension Due to (or as a consequence of):

Due to (or as a consequence of):

| 1 | 23b. | Did | tobacc | co uaa | contribute | to the o | cause of | death' |
|---|------|-----|--------|--------|------------|----------|----------|--------|
| | | 10 | Yaa | 2 N | o 3 Pr | obably | 4 🗆 U | nknow |

28f. Location (Street and Number or Rural Route Number, City or Town, Stefe)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yas 2 ☐ No

| 25. | Was case | referred to | medical |
|-----|-----------|-------------|---------|
| | examiner? | - | |
| | 1 ☐ Yes | 21710 | |

1 Dinpatient 28a. Date of Injury (Month, Dey Year) 5 Pending investigation

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t.

2 ER/Outpatient 3 DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

29a. Certifier (Check only one)

27. Manner of Death

1 (Hatural

2 Accident

3 Suicide

4 ☐ Homicide

michelle

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Drive Baltimore, mo

State

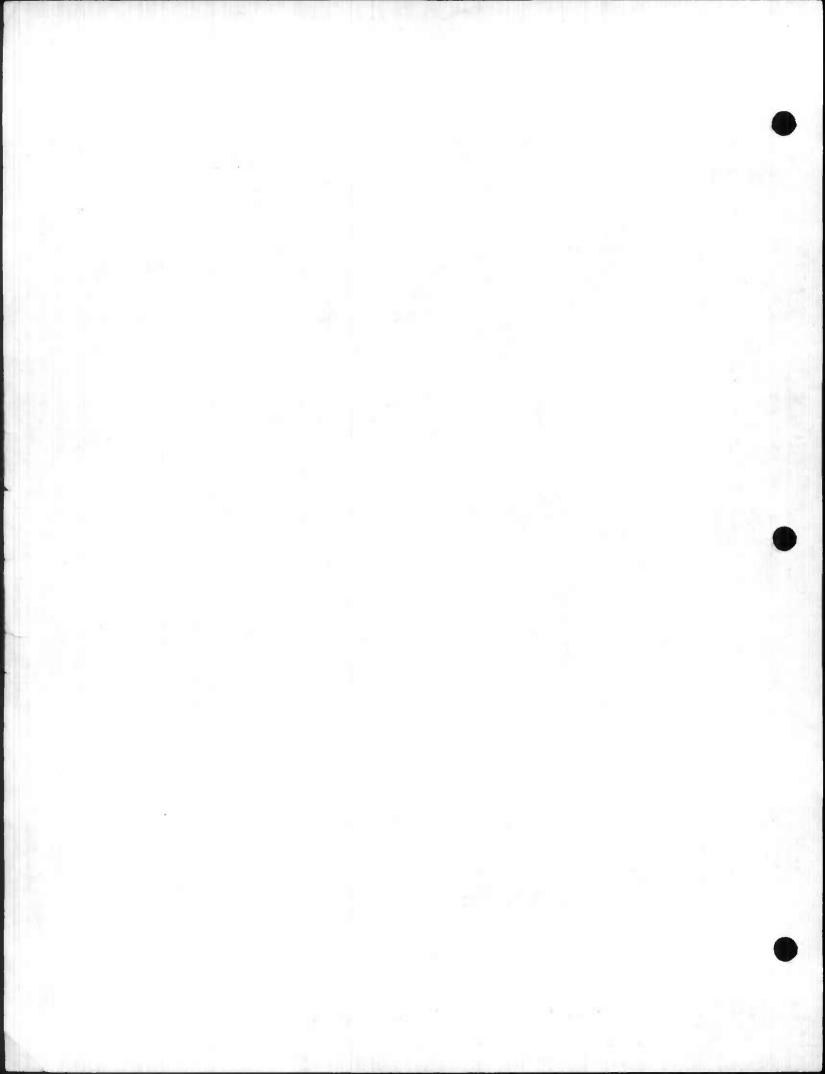
31. Date filed (Month, Dey, Year)
FEB 1 4

Boswel

6 Could not be determined

9000 MD 32. Registrar's Signature Jepeva

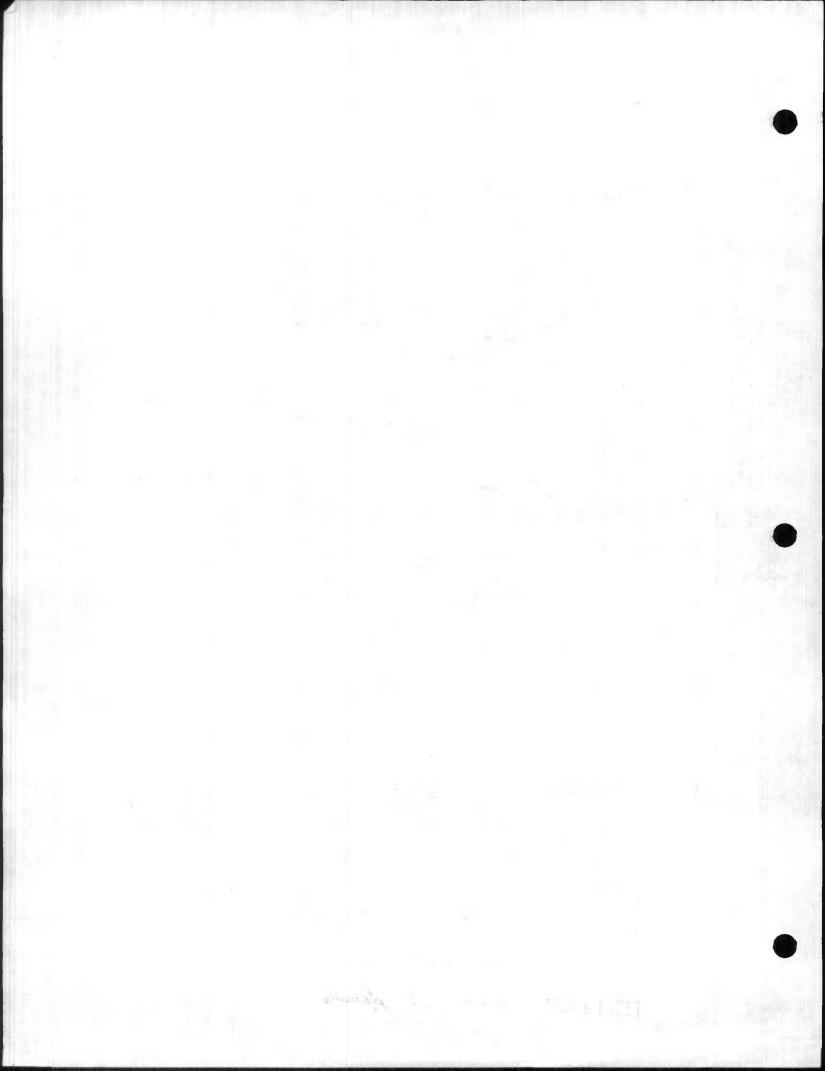
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 3 3 7

| | | | | | Cei | rtificate o | of Death | 7 | | Reg. No. | | 100. | |
|--------------------------|--|---|--|--------------------|-------------|-----------------------------------|----------------------|------------|--|---------------------|------------|---|-----|
| | | ne (First, Middle, Li | nst) | | | | | | 2. Date of De | ath | | 3. Time of Death | |
| Physician /Medical | MTT TON | C. CREDI | Æ | | | | | | FEBRUA: | Dey RY 8, 20 | Year | 3:44 AM | |
| Examiner | | If not institution, gi | | er) | | | 4b. City, T | own, or Lo | ocation of Death | | | 13.44 AU | |
| S - Amminuted | GILCHR | ТСТ | | | | | Том | son | | Rolt. | imore | | |
| Funeral | 5. Social Security I | | Sex 7. | Age (In yrs. last | birthday) | If Under 1 Ye | ar If Unde | r 24 Hra. | 8. Dete of Birt | th | 9. Birth | place (State or Foreig | רוק |
| Director | 241-12-6 Usual Residence of | 086 | 1∭ M 2□ F | 80 | Yrs. | Months De | ys Hours | Min. | 8. Dete of Bir (Month, Da Oct 25 | , 1919 | Coui | NC NC | |
| Bu | 10a. State | 10b. County | | 10c. City, T | own or Lo | cation | | | | | 1 | 10d. Inaide City Limit | 5 |
| 28s-/ sh notified | MD | Howar | d | C | olum | bia | | | | | | 1 ☐ Yes 2 N | D |
| Director | 10e. Street and Nu | mber | | | | 10f. Zip Cod | е | | | 10g. Citizen of | What Cou | ntry? | |
| | | W- | | 1 | | | 010 | | | | | | |
| 2 | 11. Marital Status | reen Mour | 12. Wes Decede | | 13.1 | Wes Decedent | 210 of Hispanic O | | ecify Yea or No | USA - 14. Bac | e - Ameri | can Indian, | |
| by Funeral | 3 ☐ Widowed | ried 2 Married 4 Divorced | Armed Force 1 K Yes 2 If Yes, Give | es? | | It Yes, apecify C | uban, Mexica | in, Puerto | Rican, etc.) | Specif. | ck, White, | elc. Lack | |
| pet | /Sne | 15. Decedent's E | ducation | 1 | 6a. Dece | dent's Usuel Oct | cupation | et of work | ina | 16b. Kind of B | usiness/In | dustry | |
| Completed | Elementary/Sec | cify only highest gr andary (0-12) | College (1-4 | or 5+) | life. | kind of work do DO NOT use rel | ned) | St Of WORK | ung | | | | |
| TO. | 12 | | | +5 | te | acher | | | | edu | catio | on | |
| Be C | | (First, Middle, Last |) | | | | 18. Moth | er's Nam | e (First, Middle, | Meiden Surnan | ne) | | |
| To | | M. Credle | 2 | | | | M | lary | M. Foxh | all | | | |
| - | | ame/Relationship | (Type, Print) | 1 | 19b. Meilir | ng Address (Stre | eet end Numt | per or Run | al Route Numbe | er, City or Town, | Stete, Zip | o Code) | |
| | Frenzela | Credle/v | vife | | 1064 | 5 Green | Mount | ain | Circle, | Columb | ia, M | ID 21044 | |
| | 20s. Method of Dis | | | 20b. Plece | e of Dispo | sition (Name of | | | Dete | 20c. Location | | | |
| | 4 🔯 Donation | ☐ Cremation 3 ☐ 5 ☐ Other (Speci | (y) | 318 | | netory or other p | | 1 | | | | | |
| 100 | 21. Signature of F | oseph Bo | Van Sant | 4 | Si | Name and Ada | dress of Fecil | Board | 655 W. | Baltim | ore S | Street | |
| | Bound | 13.76 | n Agns | | Ba | altimore | e, MD | 2120 | 1 | | | | |
| | 23a Part1 Enter | the disease, or com art failure. List only | plications that cau | sed the deeth. D | Do not ent | er the mode of | tying, such e | s cardiec | or respiretory a | rrest, | i | Approximate Intervel Between | |
| cian | | | | | | | | | | | | Onset and Death | |
| ical | Immediate Cause disease or condition | (Finel | · H | rALIN | | moct | ov | | | | | Yenra | |
| er | resulting in death) | | 0 | Due to (or es | | | | | | | | 10117 | _ |
| S | | | | DOB 10 (01 85 | e consec | (uerice oi). | | | | | 1 | | |
| Ē | | | b | Due to /or co | | | | | | - | 1 | | |
| Examiner | Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event | onditions, nmediate | | Due to (or es | e conseq | uence or): | | | | | 1 | | |
| | | injury | C | 0 | | | | | | | 1 | | |
| edicai | resulting in death) | Last | | Due to (or ea | e conseq | uence of): | | | | | 1 | | |
| 2 | | | d | | | | | | | | | | |
| clar | | | | | | | | | | | | | |
| Physician/ | Part II. Other signi | ficant conditions | contributing to deat | h but not resultin | g in the u | nderlying cause | given in Pert | I. | | A - | | o the cause of death | |
| | | | | | | | | | 10 | Yes 3 No | 3 Pro | bably 4 Unknow | MU |
| leted by Physician/N | | | | | | | | | 240 141 | an autorou | 24h W | ere autopsy tindings | |
| Š | | | | | | | | | | an autopsy amed? | av | vailable prior to empletion of cause | |
| Completed | | | | | | | | | | | of | death? | |
| Ö | | | | | | | | | 10 | Yes 2 No | 11 | ☐ Yes 2☐ No | |
| 8 | | rred to medical | | | | | 26. Plac | e of Deet | h (Check only o | one) | 1 | . / | |
| To | | No | Hospital: 1 ☐ Inp | atient 2 ER | /Outpatier | t 3 DOA | Other: 4 N | lursing Ho | ome 5 Real | dence 6 AOtt | ner (Speci | m Hospi | 3 |
| | 27. Manner of Deal | | 28a. Dete of I (Month, | njury 28 | b. Time of | 28c. lr | njury al Vork? | | | how injury occur | | 1 | |
| otte | 1 Natural 2 Accident | 5 Pending investigation | | Jay (bar) | Injury | | Yes 2 | No | | | | | |
| Medical Certification: 1 | 3 Suicide | 6 Could not be determined | 256. Place of | Injury - At home | , ferm, str | eet, factory, offic | ce | | | | ber or Run | al Route Number, | |
| Certification: | 4 Homicide | | building, | etc."(Specity) | | | | | City or To | WII, 31818) | | | |
| Cal | 29a. Certifier (Check only | Certifying Pt | nysician: To the be miner: On the basis | st of my knowled | dge, death | occurred at the | tima, date a | nd place, | and due to the | cause(s) and m | annar as s | stated. | |
| edical | ane) | | and manner | steted. | and/or in | restigation, in M | y opinion, de | em occun | eu et trie time, | vate enu piece, | PIN OUR I | o are cause(s) | |
| Σ | 29b. Signature and | sitie of certifier | / | 7 . 1 | | | ense number | | | 29d. Date signe | | | |
| | · CY | Buth | on K | de. | ni | Do | 2520 | 5 | | Febru | ANV | 8,2000 | |
| | 30. Name and add | ess of person who | completed cause of | of death Man 23 | a) (Type | Print) | | | | - 0,10 | 1 | | |
| | W.A. | Riley 1 | Samo | 1670 | / / | 1. Chm | les St. | B | elto m | d 213 | 2050 | 8,2000 | |
| State | 31. Date filed (Mor | | 32. F eg | istrar's Signeture | | Spark | 12 | 100 | | | | | |
| egistrar | FE | B 1 4 200 | JU A | , | | ppour | - 10 | | | | | | |
| | | | | | | | | | | | | | |



1. Decedent's Neme (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depa

| 2. D | ate of Death | | | 3. Tin | ne of [| Death |
|---------------------------|--------------|----|---|--------|---------|-------|
| rtificate of Death | Reg. No. | 00 | 0 | 9 4 | | U |
| artment of Health and Men | tal Hygiene | nn | | 1,5 | 33 | 8 |

| Physician | |
|-----------|--|
| /Medical | |
| Examiner | |

Funeral

Director the Meryland Phom

Pages 1 and 2 should be filed within 72 hours efter death with the Menyla neat of Heelih and Mentel Hyglene.
ant: if item 27 is marked other than "natural", or items 23s or 28s-4 show lary or other traumatic avent, the Medical Estantine must be notified as uny or other traumatic avent, the Medical Estantine must be notified. Baltimore, Maryland 21215-0020 permit. Page Department of Important: If any injury or once.

Physician /Medical Examiner

physician and the burlei-transit The law requires that the death certificate be assecuted Box 68760. 8 080 Records, P.O. page 2 Division of Vital or Attending Physician: this funeral Atter ne Hospital or Attending n 24 hours after death. Ne Funeral Director: Aft pietely filled in by the fur

Month Day Year FEBRUARY 5, 2000 Ralph Victor Chambers 1.736 PM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1600 BLK LANSING AVENUE BALTIMORE CITY If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 10 M 2□ F 34 Unknown 08-06-65 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD NA Baltimore 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1631 Lansing Avenue 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 XNo Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentery/Secondery (0-12) th Grade College (1-4or 5+) Laborer various trades 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Thomas V . David Chambers Rosemae 19a. tnformant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pritchett Catherine 3716 Monterey Road Baltimore, Maryland 21230 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 02-12-2000 Dundalk, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . GUNGHOT WOUND OFCREST Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): edical Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were sutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2□ No 25. Was case referred to medical exeminer? 8 26. Place of Deeth (Check only one) To X⊠ Yes 2□ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence & Other (Specify) AT SCENE 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury at Work? Certification: 1 DNatural 5 Pending Substitutions by Pour 1 Yes 2 No 2-5-00 17051 investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homlcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1600 BUKUANSING AVE BANNOF HO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

**Wiedlat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

State Registrar

Margarita Korell M.D. 31. Date filed (Month, Day, Year) FEB 1 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature end title of certifier

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

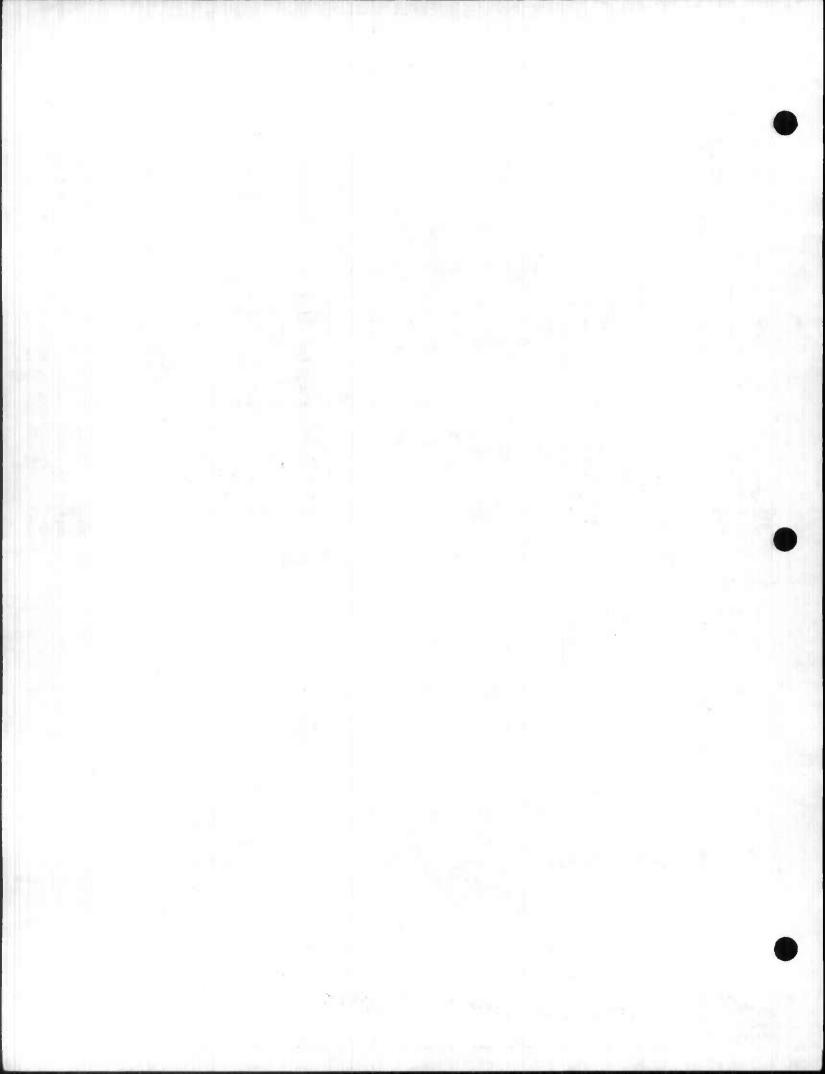
29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEBRUARY 6, 2000

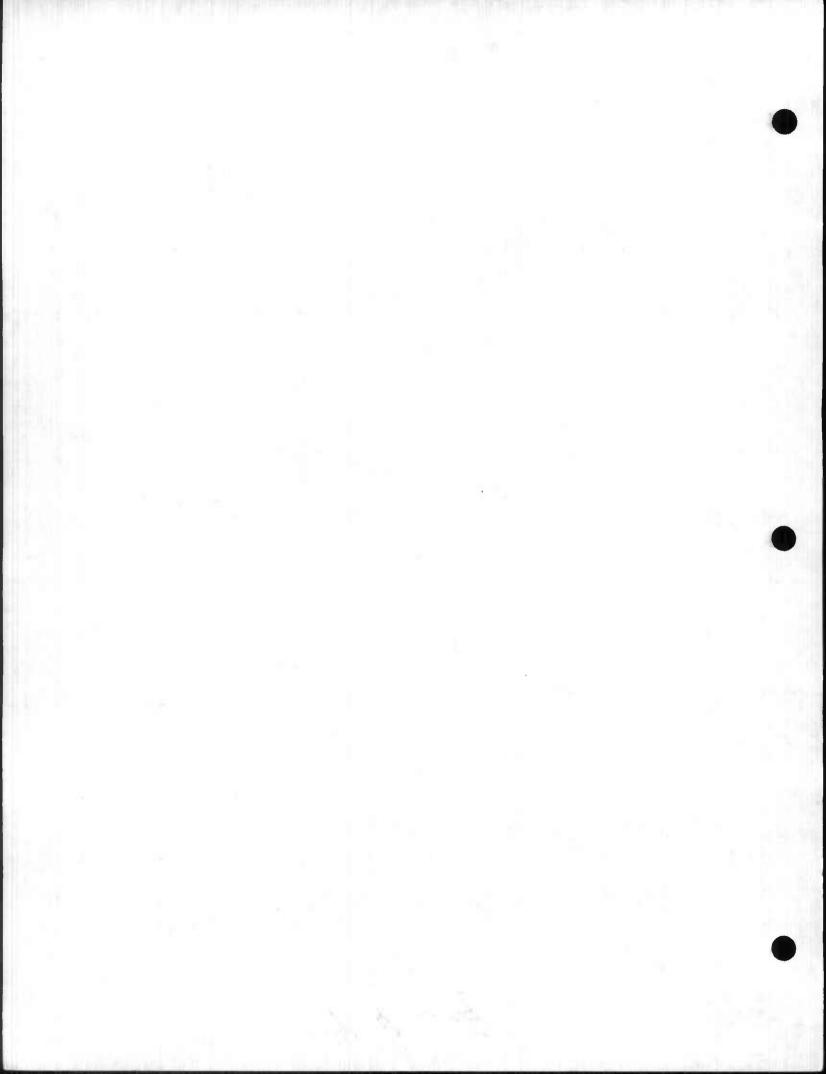
To the Hosp within 24 hor To the Fune Completely fi



State of Maryland / Department of Health and Mental Hygiene 00

00 04339

| | | | | | Ce | ertificat | e of l | Death | | | Reg. No. | | |
|---|---------------------------------|---|---------------------------------|---|-----------------------------|-----------------------------|-------------------|---------------------|-----------|------------------------------|---------------------|---------------|---------------------------------|
| | 1. Decedent's | Nama (First, Middle | , Last) | | | | | | | 2. Date of De | | Vest | 3. Time of Death |
| Physician | | JUDI | ГН | I | LENE | | CO | HEN | | Month FEBRUA | RY 10, | 2000 | 4:07 AM |
| /Medical Examiner | 4a Facility Nar | na (If not institution | | | | | | | wn, or Lo | ocation of Deat | | ty of Death | |
| Examiner | | RREN PARI | | | | | В | ALTI | ORF. | | BALT | IMORE | |
| Company | 5. Social Secur | | 6. Sex | | yrs. lest birthday |) If Unde | r 1 Yaar | If Under | | 8. Data of Bir (Month, Da | | | placa (Stata or Foreign |
| Funeral Director | | 6-1412 | 1□ M 20 | | 54 Yrs. | Months | Days | Hours | Min. | (Month, De | y, Year) 8, 1945 | Cou | intry) MD |
| Director | | ce of Decedeni | | | J-1 | | | | | DEC. 2 | 0/ 1343 | | 1110 |
| fand g m | 10a. Stata | 10b. County | | 100 | . City, Town or I | Location | | | | | - | | 10d. Inside City Limits |
| Maryta 4 show led at tor | CA | CANTRA | CLARA | | SAN | JOSE | | | | | | | 1 ☐ Yas 2 X No |
| 5 8 8 P | 10e. Street and | | CUAKA | | SAIN | 10f. Zig | Coda | | | | 10g. Citizen o | f What Cou | intry? |
| ther death with the Maryla finer a 23s or 28s-f sho inser must be notified at Funeral Director | 1819 | DRY CREEK | Z DOAD | | | | | 5124 | | | U.S.A. | | |
| 4 22 and and | 44 14 44 64 | | | Decedent Evar | in HC 42 | Was Doon | | | inin2 (Cn | pecify Yas or No | | | ican Indien. |
| or of the ch | 11. Marital Stat | | Arm | ed Forcas? | III 0,3. | If Yas, spe | cify Cuba | in, Mexica | n, Puarto | Rican, atc.) | | lack, White | |
| B 8 E | | Married 2 Marr | If Ye | Yes 2X No s, Giva | | 1 🗆 Yes | 2 No | Specify | | | Spec | city: | WHITE |
| d by | 3 LI WIOOW | ed 4 Divorced | | r or Datas: | | | | | | | | | |
| ed within 72 ho ygene. we then 'netural, it, the Medical I | 6 | 15. Decedent Specify only highes | 's Education It grada comple | eted) | (Giv | edent's Usu a kind of wo | rk dona d | du <i>rina m</i> os | t of work | king | 16b. Kind of | Businass/Ir | ndustry |
| The same of | Elemantary/ | Secondary (0-12) | Colle | ege (1-4or 5+) | | DO NOT u | | | | | MEDICA | r | |
| O Pares | | | | | A-RA. | Y TECH | INTCI | | | MEDICAL | | | |
| d other event, | 17. Father's Na | ma (First, Middla, | | | LIDDDA | | | | | a (First, Middle | , Maiden Sum | | NOTITE ! |
| Menta | DAVID | · | н. | | WERBA | | | MILI | DRED | | | | COHEN |
| 2 sho and is ma | | 's Name/Ralations | | - | | | | | | rei Route Numb | | | |
| CHNE | ALAN | WERBA / 1 | BROTHER | | 1819 | 9 DRY | CREE | K RO | 4D - | SAN JO | SE, CA | 95124 | |
| et 1 and of Health I hern 27 r other t | 20a. Mathod of | • | | | Ob. Place of Disposerry, cr | position (Na | ma of | 2a) | | Data | 20c. Locatio | n - City or T | Town, Steta |
| Paget net of ny or o | | 2 ☐ Cremation ion 5 ☐ Other (S) | | | GUDAS A | | | | ין מפ | 2/11/00 | ROSE | DALE | MD |
| - 日春三 | | of Poneral Service | | | - | 22. Nama ai | | | | 2/11/00 | NOSI | י מניטטני | TID |
| permit. Departi Importa any inji | SOL LEVINSON & BROS. | | | | | | | | | | | | , INC. |
| | | | | | | | | | | | | | MD 21208 |
| | 23a. Part1. Er shock, or | iter the disease, or heart failura. List | complications only ona cause | that edused that on each line. | daath. Do not a | ntar tha mod | de of dyin | g, such as | cardiac | or raspiratory a | irrest, | | Approximata Intarval Batween |
| Physician | | | | | | | | | | | | 1 | Onsat and Death |
| /Medical | Immediata Car disaasa or con | | | α | etastatic | M | la MOP | 10 | | | | | 20 yers |
| Examiner | rasulting in de | | 8 | | to (or as a cons | | | | | | | | 3 |
| ةِ السَّادِينَ | | | | | | | | | | | | | |
| death certificate be executed e attending physician and tot use as the burial-transit siciar/Medical Examiner | Sequentially lis | st conditions | b. —— | Dua | to (or as a cons | equence of) | | | | | | 1 | |
| Ex institute | if any, leading | to immediata | | | | , | | | | | | 1 | |
| ifficete be set g physician as the burial | Cause (Diseas | se or injury vents | c | Dua | to (or as a cons | equanca of): | | | | | | | |
| edi the | resulting in dea | ath) Last | | 500 | 10 (01 43 4 0013 | squarioa or). | | | | | | | |
| ath certification of the rate at the search of the rate at the search of the rate at the rate of the r | | | d | | | | | | | | | - | |
| that the death conditions attend detached for us | | | | | | | | | | 1 201 71 | | | |
| the d by the achec | Part II. Other s | ignificant conditio | ns contributing | to death but no | t rasulting in tha | undarlying | causa giv | en in Part | I. | | ~ | | to the cause of death? |
| hat the detay detay | | | | | | | | | | 1 🗆 | Y88 2 2 N | 3 Pr | obably 4 Unknown |
| 2 6 8 C | | | | | | | | | | | | 0.45 | Man autonou fin dis as |
| equi soulc | | | | | | | | | | | an autopsy ormed? | 8 | Ware autopsy findings |
| > 0 0 | | | | | | | | | | | | 0 | completion of cause of daalh? |
| The lew requir | | | | | | | | | | 10 | Yes 2 No | 1 | □ Yas 20 No |
| certificate has irector, page 2 | | referred to predical | | | | | | 26 Plac | a of Dea | th (Check only | onal | | |
| Physician: this certific ral director, | axaminer? | 2 100 | Hospitel: | 1 Inpatient | ∩∏ EB/Outrot | ant 200 D | OA Oth | or. | | | | Whee /Free | TEMPORARY |
| | 27. Manner of I | 7 | 288 | | 2 ER/Outpati | | | | ursing m | oma 5 2 Ras 28d. Describe | how injury oc | Other (Spec | RESIDENCE |
| tal or Attending P is after death. al Director: After ted in by the funeral Certification: | Natura | 5 ☐ Pendin | | Deta of Injury (Month, Day Yea | (Injury | м | 28c. Injur Wor | k? Yas 2□ | l No | | | | |
| f or Attending after death. Director: After d in by the fune ertification | 2 ☐ Accida 3 ☐ Suicid | | not be | Diameter (1.1 | A44 | | | | 110 | 20f Location | (Cernat and Mu | mhar as Bu | ral Route Number, |
| after day after day din by | 4 Homic | datam | ined 289. | Plece of Injury - building, atc. (Sp | At nome, term, : Decify) | streat, factor | у, опісв | | | | wn, Steta) | INDEL OF HU | rai ricute rumper, |
| C III D | | | | | | | | | - | | | | |
| ne Hospi in 24 hou he Funer pletely fil | 29a. Cartifier (Check onl | | | o the best of my | | | | | | | | | |
| To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | one) | | and | mannar stated. | | | | | | | | | |
| To To To | 29b. Signatura | and title of certifier | | | | 29 | c. Licans | a number | | | 29d. Data sig | ned (Month | h, Day, Year) |
| 10- | Mu. | MA | | MD | | | 03 | 8400 | i | × : | 410/00 | > | |
| | 30. Nama and | addrass of person | who completed | causa of daath | (Item 23a) (Type | e, Print) | | | | | 1 | | |
| S | WILLIA | | | 1075. | | L Rd | F | F 41 | 5.1 | Lamoron | w, M | d 2 | 1093 |
| Ctots | 31. Data filed (| | 4 4 4 4 | 32. Registrar's S | | - , (| | ** | - / | | | | |
| State Registrar | | FEB | 14 20 | . Se | neva | 4 | _ | S | | | | | |
| riegistrai | | | | - | | 10. | An | 2. 11 | 4 | | | | |



State of Maryland / Department of Health and Mental Hygiene 04340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PETER THOMAS DAVID FEB 2000 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days 10XM 2□ F Months Hours Min Yrs. Director 02-08-2000 MD Usual Residence of Decedent death with the Manyand 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flerns 23a or 28a-f show the Medical Examiner must be notified at 1 X Yas 2 □ No Director Fairfax Herndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 763 Dranesville Road Funeral 20170 USA 12. Wes Decedent Ever in U,S. Armed Forcas?

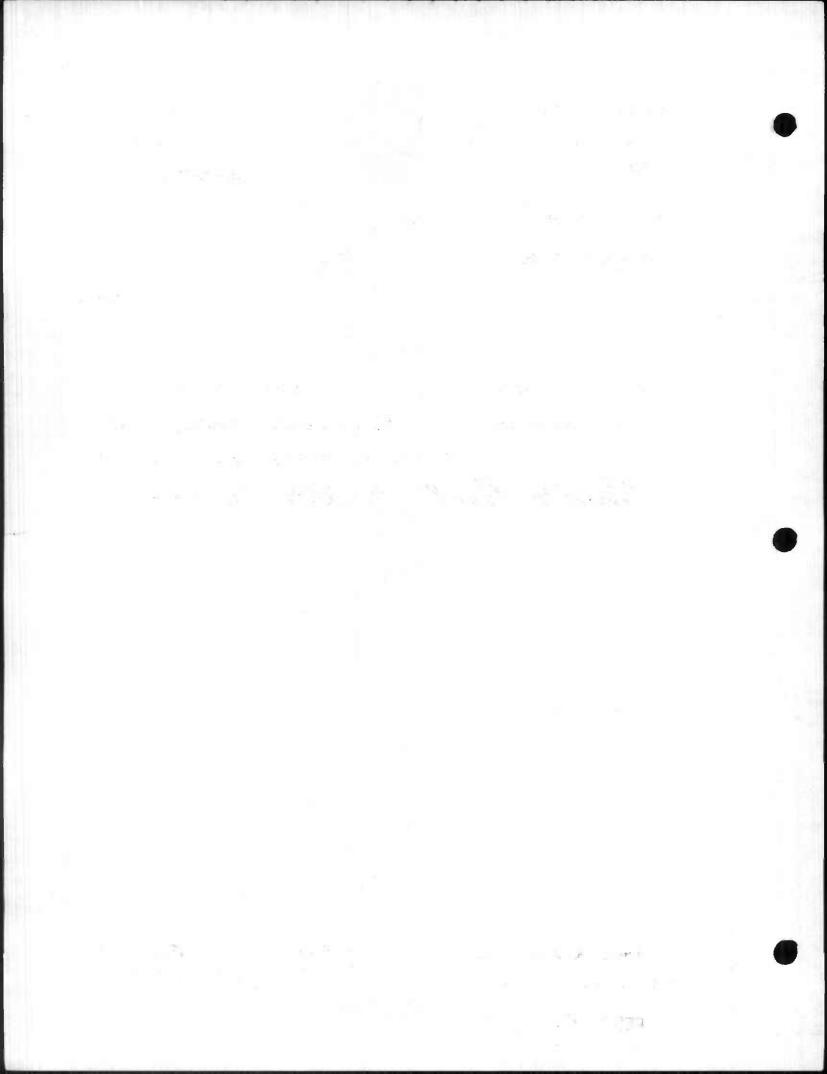
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or fies any Injury or other traumatic event, the Medical Examina. Bleck, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 XNo Specify ρ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joshua 2 David Moira Cradock 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Father / Joshua David 763 Dranesville Rd. Herndon, VA 20170 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Chestnut Grove Cemetery 2-15-00 Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Green Funeral Home, Inc.
721 Elden St., Herndon, V
23a. Part1. Enter the disease, or complications that caused the greath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. VA 20170 Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a. SPINAL-MUSCULAR ATROPHY Examiner Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 11 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at tha time, date and piace, and dua to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D41551 Russell R TUNK Feb 11, M 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MOORES, RUSSELL, LTC, USA BETHESDA, MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar'a Signeture State

Registrar

FEB 1 4 2000 **DHMH 16 Rev 6/95**

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Valerie Lynne Doeller February 10 2000 1:15 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospice at Gilchrist Towson H Under 24 Hrs. B. Date of Birth (Month, Day, Year) October 2,1946 5. Social Security Number If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days 1 M 2 XF Months Maryland 213-48-8041 53 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore Freeland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21053 20023 Gore Mill Rd. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2XX Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) program administrator insurance 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Irving Brose Evelvn Meier 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freeland, MD 21053 David L. Doeller/husband 20023 Gore Mill Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Steta 4 ☐ Donetion 5 ☐ Othar (Specify) 2/11/00 Baltimore, Maryland Greenmount Crematory 21. Signeture of Funarel Sarvice Licenses 22. Nama and Address of FacilityMitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final disaese or condition resulting in death) letter mo Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? VASCULANDIBERSE With 1 Yes 2 KNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICA Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2√No 27. Manner of Death 26d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DiNetural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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Physician/Medical Completed by Be Certification: To funeral the f

Physician

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Examiner

Funeral

Director

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= à permit. Page Department o important: If any injury or

Physician /Medical

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Baitimore, Maryland

2000

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(Check only one)

29a. Cartifier

State Registrar

Medical

29b. Signature and the of dortifier,

🔯 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date aigned (Month, Day, Year)

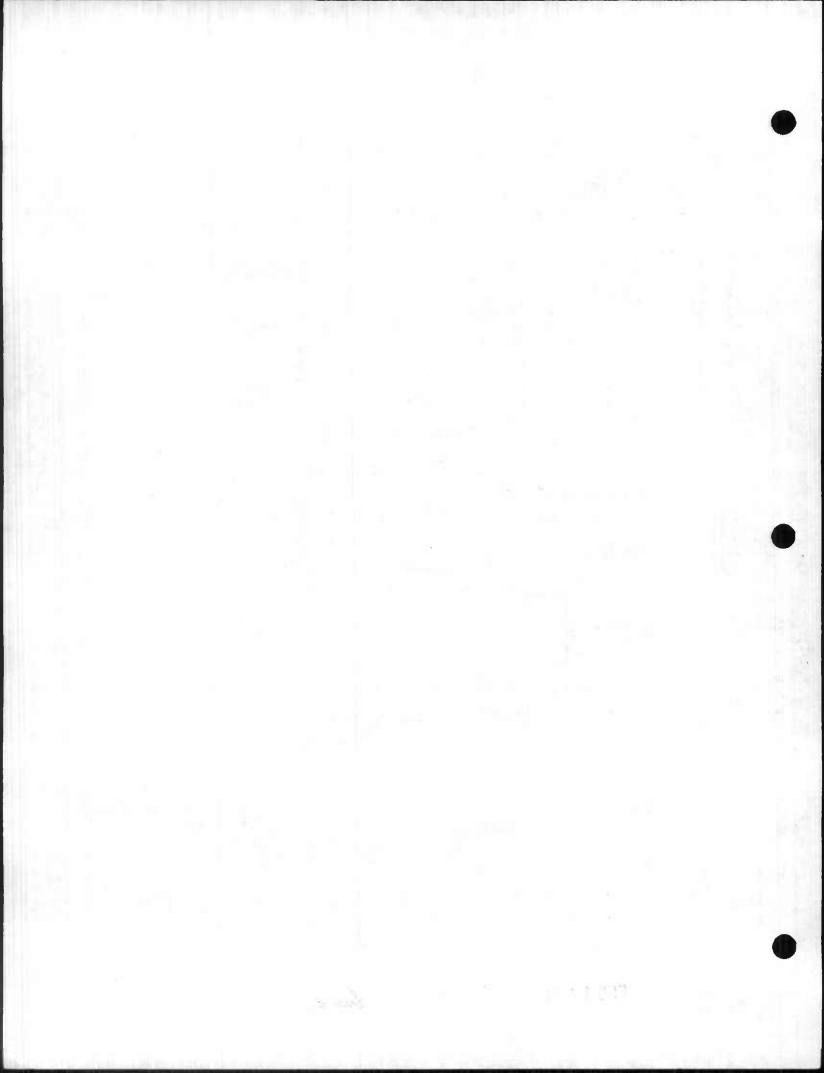
Balto, md

no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. C. Ley G. B.M.C. 670 N. Chyrlos

31. Date filed (Month) Law 2000 | 32. Replices Expending (M.)



Box 68760 P.O. Division of Vital Records, after death Director:

the Maryland

Baltimore, Maryland 21215-0020

27. Manner of Death
1 A Netural
2 Accident 5 Pending investigation 6 Could not be 3 Suicida 4 Homicide

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28a. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 2-10-00

Mana and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

#304 Severna Parke MD 21146

State Registrar

Medical

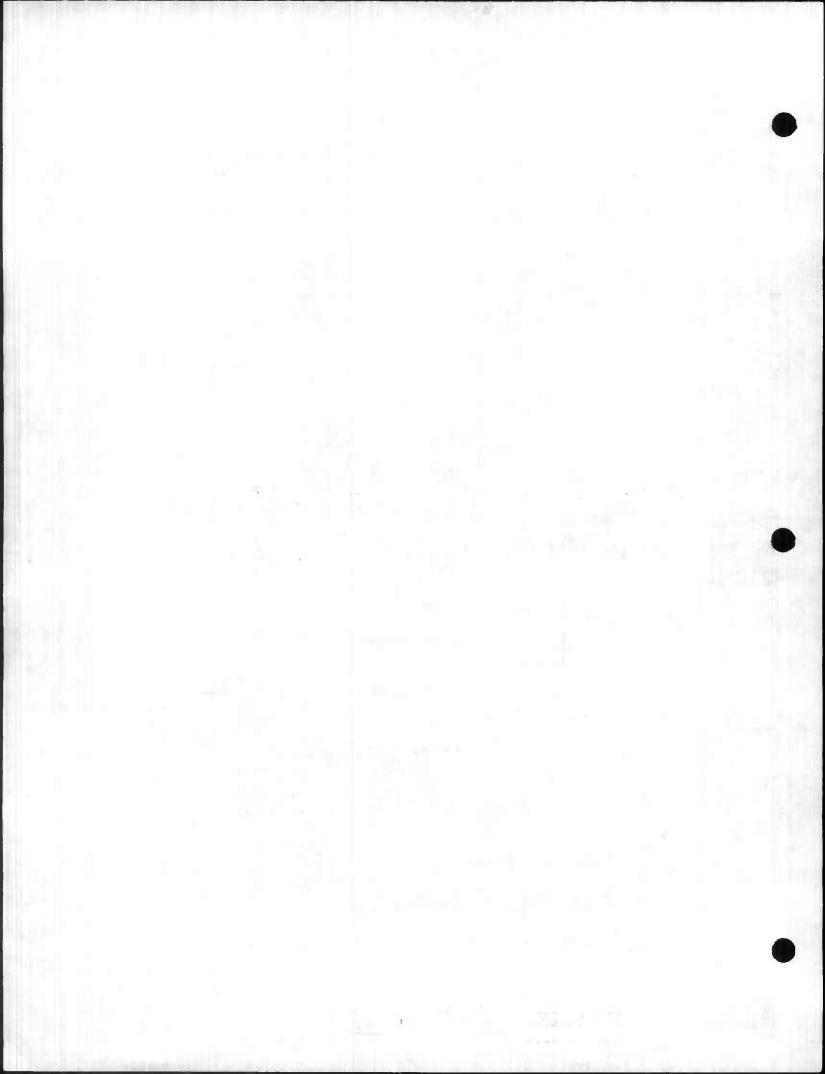
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32. Registrar's Signeture Gener

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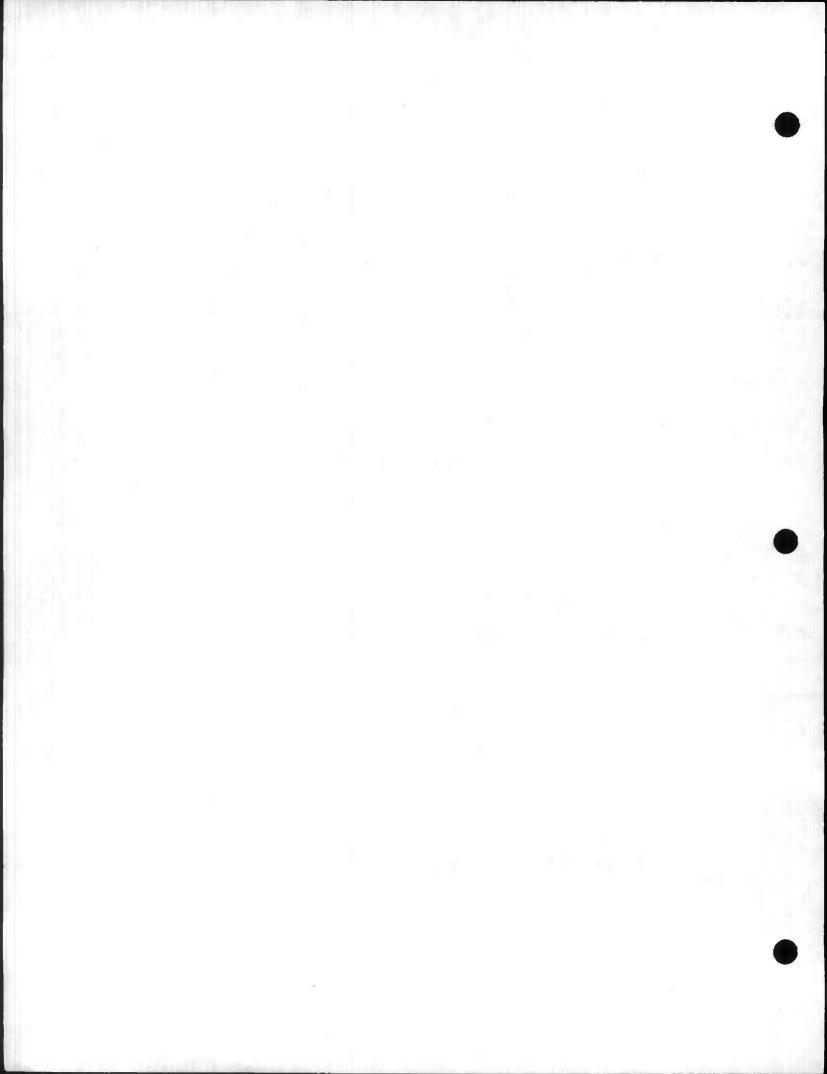


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State of Maryland / Department of Health and Mental Hygiene 00 04343

| | | | | | | Ce | rtificat | e of | Death | | F | leg. No. | | | |
|--|----------------------------|---|--|----------------------------------|--|--|-----------------------------|---|---|--------------------------|--|-----------------------------------|------------------------|--|----------------|
| Di -i-i- | | ecedent's Name | (First, Middle, La | est) | | | | | | | 2. Date of Dea Month | th Day | Year | 3. Time of | Death |
| Physician /Medical | | OF A | MOLLE | | | EL | LIS | | | F | FEBRUAR | | 000 | 1:30 | AM |
| Examiner | | | not institution, gir CARE NUR | | | | | | 4b. City, To RANDA | | cation of Death | 4c. County BALT | of Death | E | |
| Funeral Director | | ocial Security Nu 061–18–4 | | Sex 1□M 2⊠F | 7. Age (In yrs 95 | . lest birthdey Yrs. | Months Months | Days | If Under: Hours | Min. | 8. Date of Birth (Month, Dey MAY 12, | , Year) 1904 | 9. Birthp Cour | plece (State ontry) RUS | |
| , | 1 | al Residence of | | | 100.0 | itu Teum es l | ti | | | | | | | 10d Inclds C | Star I locali |
| 28a-f ahow notified at | | . State MD | BALTIM | ORE | 100.0 | RANDA | | WN | | | | | | 10d. Inside C | |
| me 23a or 28a-f show c must be notified at neral Director | 10e | Street and Num 5412 OLI | D COURT | ROAD | | | 10f. Zip | | 21133 | | | 10g. Citizen of \ | What Cour | u.S.A | • |
| 5 E | | Marital Status 1 ☐ Never Marrie 3 ☐ Widowed | | Armed F | 2 XNo | J,S. 13. Was Decedent of If Yes, specify Cul | | cify Cub | Hispanic Origin? (Specify Yes or Noan, Mexican, Puerto Rican, etc.) Specify: | | city Yes or No- Rican, etc.) | Black, White, etc. | | | |
| han 'na' Nado Mplete | E | | 15. Decedent's E fy only highest gr idary (0-12) | | | (Give | DO NOT u | it's Usual Occupation id of work done during most of wor NOT use retired) FF: | | t of workin | rking 16b. Klnd | | d of Business/Industry | | |
| d out | 17. | Fether's Neme (I | First, Middle, Las | ") | | | | | 18. Mother's Name (First, Midd | | | Maiden Sumen | | | |
| marke umatic | - | HENRY | | | | ZAMAR | | (0) | LEA | | (unkno | - | Ca- 4- 70 | - 0 - 1 - 1 | |
| f Health and Meritem 27 is market other traumatic | | | Me/Reletionship | | ER | | | | OOD R | | | E, MD | | | |
| | 20a | | Cremation 3 | | State | Placa of Disp cametery, cre | osition (Ne metory or o | me of other ple | ce) | 1 | Date | 20c. Location | - City or To | own, State | |
| Department of Important: If any injury or pace. | 21. | | 5 Other (Speci | ** | BE | TH EL | | | SS of Facilit | oc v | 111/2000 | RANDAL | | | |
| Oepa Impo any i | | Aca | M The | list | the | 8 | 900 R | EIST | ERSTO | | | SON & B | | | .08 |
| nysician | 236 | a. Part1. Enter th shock, or hear | e diseese, or con t feilure. List only | nplications that one cause on | caused the dea each line. | ith. Do not er | iter the mod | de of dyi | ng, such as | cardiac or | r respiratory ar | rest, | | Approximatinterval Bet Onset and | tween |
| Medical caminer | dise | nediete Cause (F ease or condition ulting in death) | inal | a A | - | or es e conse | | | 515 | | - | - | 1 | 20 y | ear |
| g physician and as the bural-transit ledical Examiner | Sec if an cau Cau | quentially list con ny, leading to imi se. Enter Under use (Disease or I t initiated events ulting in death) L | njury | b | | or as a conse | | | | _ | | | | | |
| usa as t | | oning in dodding c | | d | | | | | | | | | | | |
| the attanding physicial hed for usa as the but ysician/Medical | Part | II. Other signific | cant conditions | contributing to d | leath but not re | sulting in the | underlying (| cause gi | ven in Part I | | 23b. Did 1 | obacco use co | ntribute f | to the cause | of dea |
| d by atac | | | | | | | | | | | 10 | Yes 20 No | 3 Pro | obably 4 |) Unkno |
| ate has been signed in page 2 should be detected by P | _ | | | | | | | | | _ | 24e. Was perfo | an autopsy med? | an | Vare autopsy vallable prior ompletion of f death? | to |
| ate has paga 2 Comp | | | | | | | | | | | 101 | res 2 No | 1 | ☐Yes 2□ |] No |
| cartificate rector, pag | 25. | Was case referre | ed termedical | | | | | | 26. Place | of Deeth | (Check only o | ne) | | | |
| 9 0 | | axaminer? 1 ☐ Yes 2 ☐ ₫ | No | Hospital: | Inpatient 2 | ER/Outpatie | ent 3 De | OA Oth | ner: 4 Nu | irsing Hon | ne 5 Resid | lence 6 🗆 Oth | ner (Speci | ity) | |
| Attar funa fon | 27. | Manner of Death Neturel Control Control | 5 Pending investigation | on | of Injury nth, Dey Year) | 28b. Time tnjury | of M | 28c. Inju Wo 1 [| ryat rk? ∣Yes 2 🗆 | | 28d. Describe h | now injury occur | rred | | |
| ST F | | 3 Suicide 4 Homicide | 6 Could not be determined | 28e. Plec build | a of Injury - At I ling, etc. (Spec | nome, ferm, s ify) | treet, factor | y, offica | | 2 | 28f. Location (5 City or Tox | Street end Num vn, Stete) | ber or Rur | re/ Route Nur | n <i>ber</i> , |
| within 24 hours e To the Funeral I completely lilled Medical Ce | 298 | Certifier (Check only one) | 12 Certifying Pl 2 Medical Exa | miner: On the t | best of my kn pasis of examin oner stated. | owledge, dea ation and/or i | th occurred nvestigetion | et the ti | me, dete en opinion, dee | d pleca, e th occurre | and due to the ed at the time, | cause(s) and m date and placa, | annar as a | stated. to the ceuse(| s) |
| within To the comp | | . Signature and t | itle of certifier | // | -0 | | 29 | c. Licens | se number | | | 29d. Date signe | d (Month | , Day, Year) | |
| | 20 | Name and add | sa of person who | - Gt | en of death (to- | 17 (Turn | Deint | D002 | 20964 | | I | ebruary | , 8, | 2000 | |
| 1 | J | erome H | Ginsbe | rg, M.D | . 863 | 30 Libe | | Plaza | a Mall | R | andalls | stown, M | 1D 21 | 133 | |
| State Registrar | 31. | Date filed (Monti | -EB'91'4 | 200- 32.1 | Registrar's Sign | ature | 6 | | | | | | | | |

DHMH 16 Rev 6/95



The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, or Attending Physician: To the Hospital or within 24 hours aff To the Funeral Di complataly filled in

MOCHTE

Funeral

Director

must be notified

the Medical Examiner on

Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland ment of Health and Mentel Hygiane.
Inttit if them 27 is marked other than "natural", or items 28a or 28e-f show

or other tre

Department of Important: If any injury or

Physician

Examiner

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page 2 should be detached

After this cartificate has

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eral Director: After this cartificatilised in by the funeral director,

/filedical

21215-0020

Baltimore, Maryland

State Registrar

29a, Certifier (Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

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32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANIMIAM

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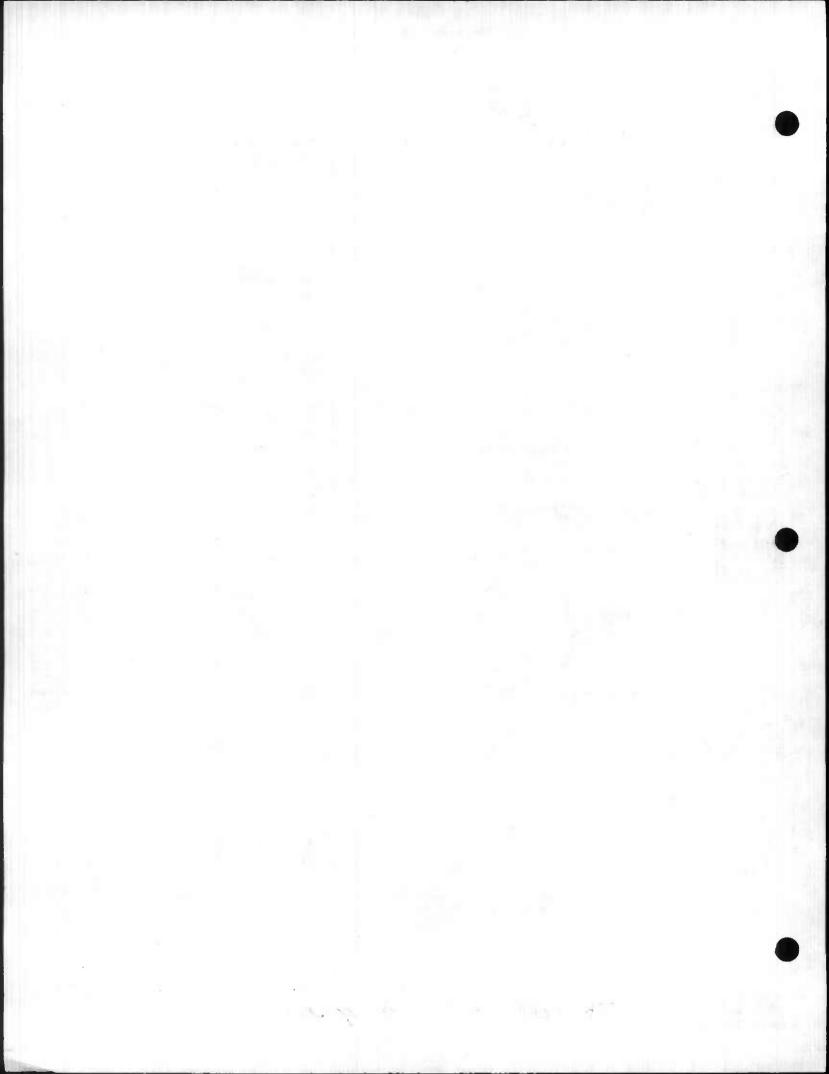
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

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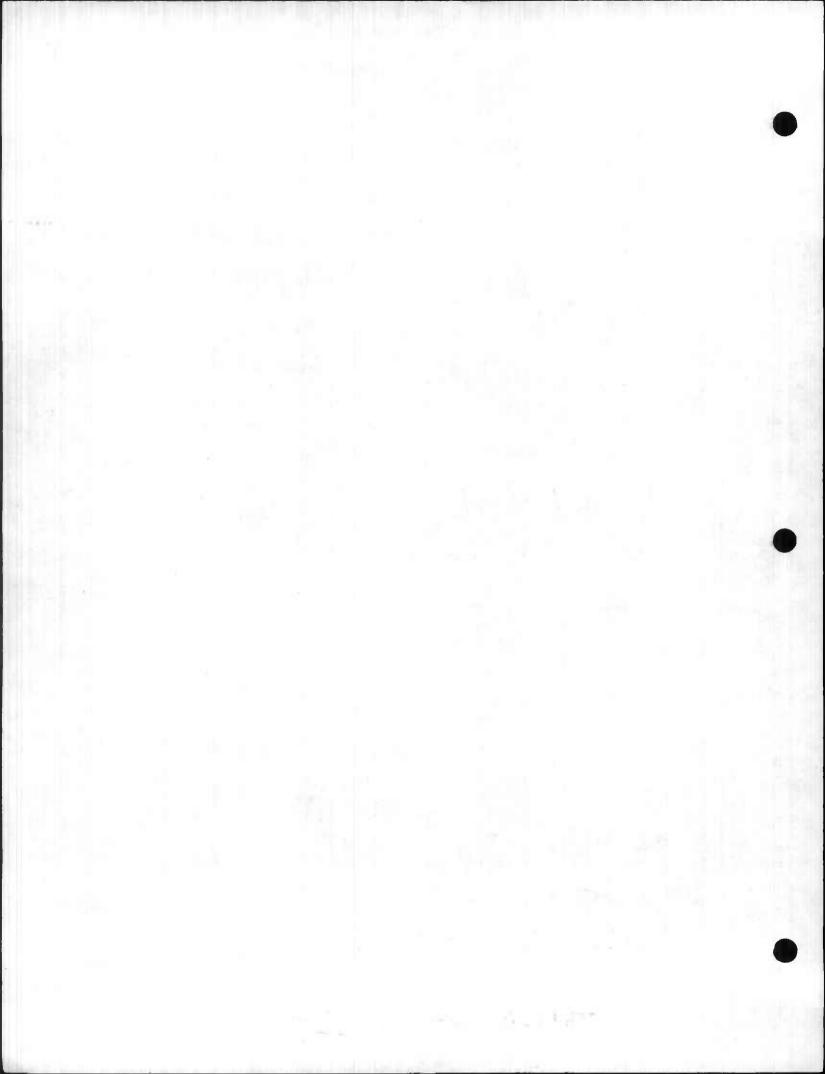
29c. License number

29d. Date signed (Month, Day, Year)



ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Year Month RUTHANN **FOX** FEBRUARY 4, 2000 4c. County of Deeth 1:35 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL Frederick Frederick 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 WV Hours Months Days 1 □ M 2 X F Dec 15, 233-32-6872 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Fredeick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 Rock Creek Drive 21702 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 Married white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 housewife unknown own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wayne F. Sutton Ruth S. Norcross 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Fox/husband 1608 Rock Creek Drive Frederick MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Joseph Bo Van State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of):

Physician /Medical Examiner

physician and the burial-transit

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The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

or Attanding death.

To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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il Hygiene.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygient important; if Nem 27 is marked other that any Injury or other traumatic.

Baltimore, Maryland 21215-0020

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| resulting in death) Last | d. | or es e consequence orj: | | | |
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| Part II. Other algorificant conditions of | contributing to death but not re | sulting in the underlying ca | ause given in Pert I. | 23b. Did tobacco use co | ontribute to the cause of death? 3 Probably 4 Unknow |
| 0 | 0 | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| | | | | 1 ☐ Yes 2 No | 1 ☐ Yas 2 ☐ No |
| 25. Wes casa referred to medical examiner? | | | 26. Place of De | eeth (Check only one) | |
| 1 Yes 2 10 | Hospitel: 1 Inpatient 2 | ☐ ER/Outpatient 3☐ DO | A Other: 4 Nursing | Home 5 ☐ Residence 6 ☐Ott | her (Specify) |
| 27. Menner of Death 1. Neturet 5 □ Pending 2 □ Accident Investigatio | | 28b. Time of Injury M | Bc. Injury et Work? 1 Yes 2 No | 28d. Describe how injury occu | rred |
| 3 Suicide 6 Could not be determined | | | | | |
| 29a. Certifier (Check only one) Certifying Pr | ysician: To the best of my known. On the basis of examine end menner steted. | owledge, death occurred a etion and/or investigation, | nt the time, date and place in my opinion, death occ | e, and dua to the cause(s) and m curred et the time, dete end plece, | anner as stated. and due to the cause(s) |

29c. License number

FRED ERICK

29d. Date signed (Month, Day, Year)

2000



State Registrar

29b. Signature and title of certifier

Date filed (Month, Day, Year)

address of person

SON

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30. Nama and

Allen

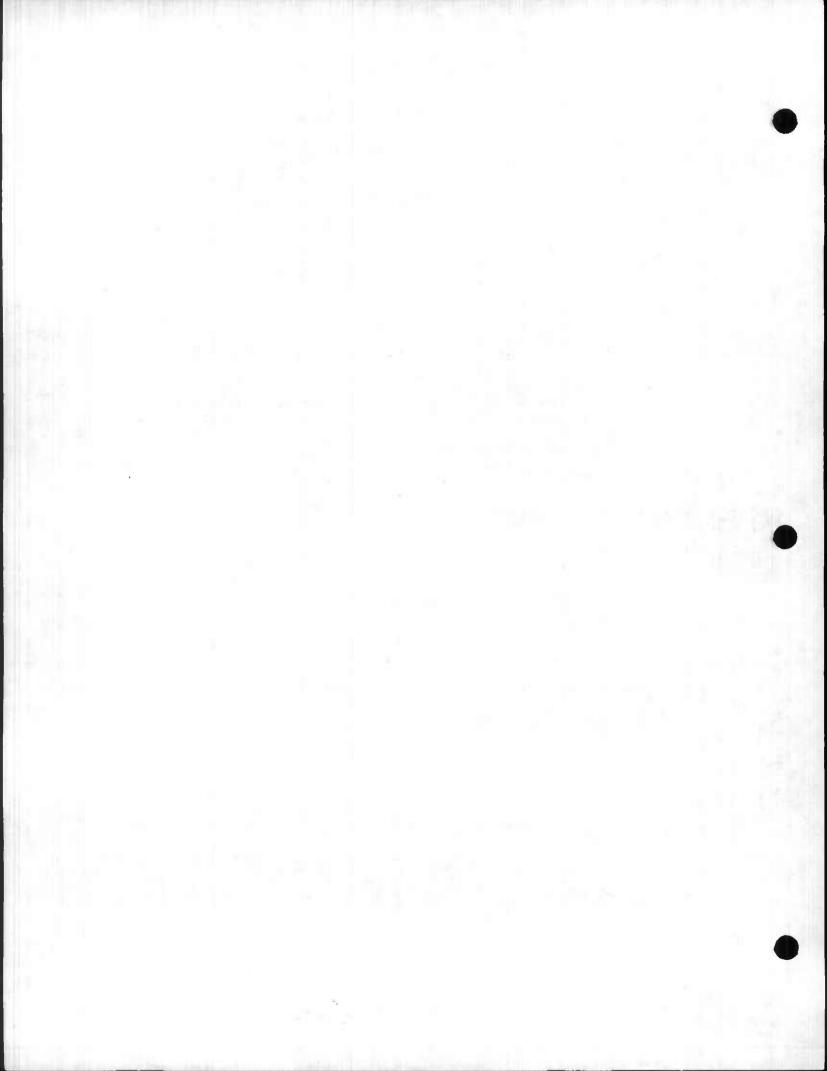
DHMH 16 Rev 6/95

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TANE

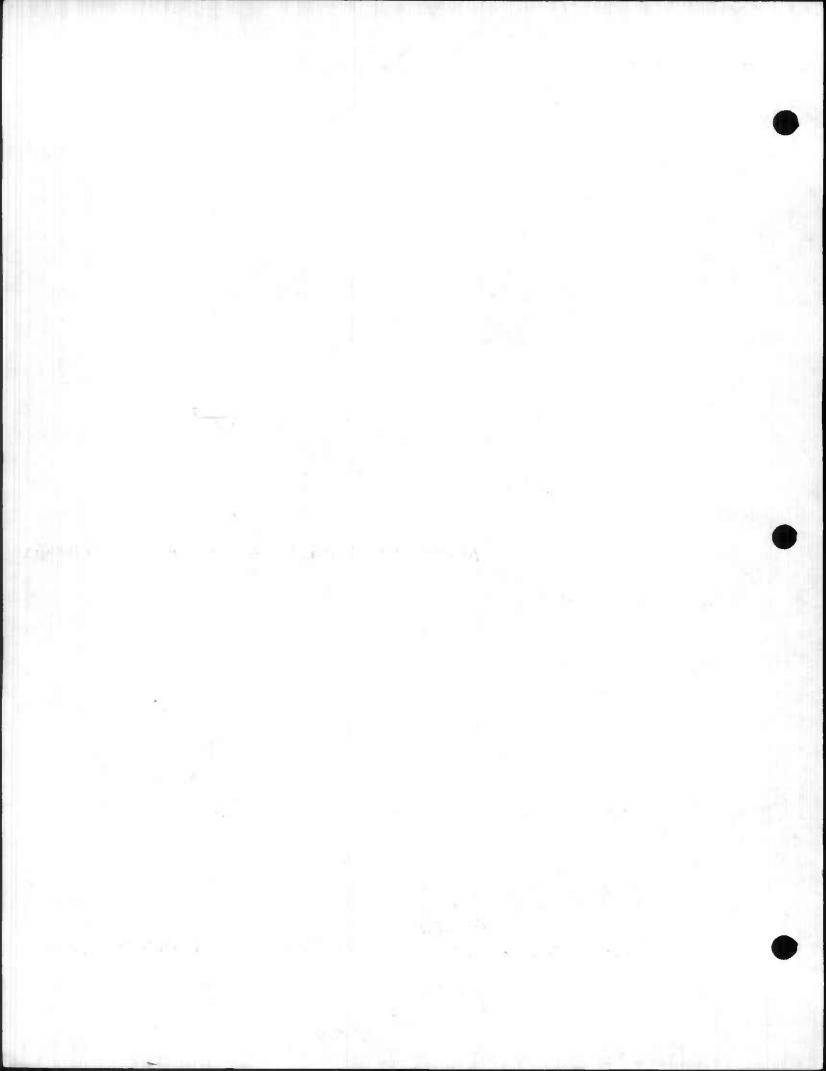
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| EM #19t | b | PER FH G780 2/14/2 | | | | | tificate | | | | ental Hy | giene U Reg. No. | U | 04347 |
|--|--------------------------------|--|------------------------------------|---|-------------------------------|-------------------------|---|-----------------|---------------------------------------|-----------------|-------------------------------------|--------------------------------|-----------------|--|
| nysician | ľ | . Decedent's Neme (First, Midd | | | | | | | | | 2. Date of De Month | Dey | Yeer | 3. Time of Deeth |
| Medical aminer | 1 | PAUL a Facility Name (If not Institution | | d number) | | GR | EENBA | - | 4b. City, To | | FEBRUA cation of Deet | | | 5:00 PM |
| ner | | 7111 PARK HEI | | | #308 | | | E | BALTI | MORE | | | | N/A |
| il r | 5 | Social Security Number 046-03-5786 | 8. Sex 1 ☐ M 2 🔀 | | e (In yrs. lasi 88 | birthday) Yrs. | If Under Months | Year Deys | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, Di AUG. | | 9. Birth Cou | place (State or Foreign ntry) N.Y. |
| | - | Jsuat Residence of Decedent Oe. Stete 10b. County | | | 10c. City, T | own or Lo | cation | | | | | | | 10d. Inside City Limits |
| ō | | MD N/A | | | | BALTI | | | | | | | | 1 N Yes 2 No |
| Director | 1 | 0e. Street and Number | | | _ | | 10f. Zip | Code | | | | 10g. Citizen of | What Cou | intry? |
| a D | | 7111 PARK HEI | GHTS AV | ENUE | #308 | | | 2 | 21215 | | | U.S.A. | | |
| by Funeral | | 1. Meritel Status 1 ☑ Never Merried 2 ☐ Mer 3 ☐ Widowed 4 ☐ Divorced | ried 1 1 | Decedent of Forces? Yes 2 X Poss, Give or Dates: | Ever in U,S. | | Vas Decede I Yes, speci I □ Yes 2 | | lispanic Or en, Mexica Specify: | | cify Yes or N Rican, etc.) | 14. Ra Ble Specif | ck, White | can Indian, , atc. WHITE |
| ted | T | 15. Deceder (Specify only higher | nt's Education | ted) | 1 | 6a. Deced | lent's Usuel kind of work | Occup | ation | st of worki | na | 16b. Kind of B | usiness/I | ndustry |
| Completed | | Elementery/Secondery (0-12) | | ge (1-4or 5 | 5+) T | life. L | SECRI | retired | 1) | | | LAW | | |
| | | 7. Father's Neme (First, Middle | Last) | | 1 | THOU | DECKI | 1 1 1/1 | | er's Neme | (First. Middle | , Meiden Sumai | ne) | |
| o Be | | JULIUS | , | | GF | REENB | AUM | | ROSI | | , | | , | ROSEN |
| - | 19a. Informant's Neme/Retetion | ship (Type, Print) |) | | 19b. Meilir | g Address | | and Numb | er or Rure | | per, City or Town | , State, Zi | | |
| | | EDNA LEVINE / | SISTER | | | 7111 | PARK | HEI | GHTS | AVEN | UE #30 | 6 ⁷⁰⁴ BAL' | PIMOR | E, MD 2121 |
| | 2 | 0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3V Romovel 6 | rom State | 20b. Pled cem | e of Dispo | sition (Nemnetory or of | e of | | | Dete | 20c. Location | - City or T | own, Stete |
| | | 4 □ Donetion 5 □ Other (5 | specity) | tom Stele | FIRS | r LUD | MIR B | ENE | VOLEN' | T 2/ | /11/00 | WEST H | ARTF | ORD, CT |
| đị. | 1 | 21. Signature of Funerel Service | Montey | 1 | | 22 | . Name end | Addre | ss of Fecili | | r. r.evt | NSON & I | RPOS | TNC |
| etached for use as the burial-transit Laboration Physician/Medical Examiner | | mmediate Cause (Finet disease or condition esulting in death) Sequentially list conditions, I any, leading to immediate ause. Enter Underlying Cause (Disease or hjury het initiated events esulting in death) Last | b c | | Due to (or as | s a conseq | uence of): uence of): | | | | PRCIN | | ontributs | Onset end Deeth Swould to the cause of death? |
| / Phys | | | | | | | | | | | | Y88 2 XNO | | obably 4 Unknown |
| Completed by | - | | | | | | | | | | 24e. We perf | s an eutopsy omed? | a | Vere autopsy findings valiable prior to ompletion of cause f death? |
| | | | | | | | | | | | 1 🗆 | Yes 2 Nio | 1 | Yes 2 No |
| Be | 1 | 5. Wes case referred to medical examiner? | Hospitel: | | - 5 | | -50.00 | Oth | ar. | | (Check only | | | |
| : To | | 1 ☐ Yes 2 No 7. Menner of Death | 28a. D | 1 Inpatie | ry 28 | VOutpetier 3b. Time of | | c. Injur Wor | 4014 | ursing Ho | 2 44 5 | how injury occu | | ify) |
| tor | | 1 Naturel 5 Pendi | | Month, De | y Year) | Injury | м | | rk? Yes 2⊡ | | | | | |
| Certification: | | 3 Suicide 6 Could determ | ningd 200. F | Plece of Injusting, etc. | ury - At home c. (Specify) | e, farm, str | eet, factory, | office | | | 281. Location City or To | (Street and Num own, State) | ber or Ru | rel Route Number, |
| Medical | 1 | | ng Physician: To Examiner: On t | | examinetion | | | | | | | | | |
| N N | 1 | 9b. Signature end title of certific | | A | 4 0 | .: | 29c. | Licens | e number | | | 29d. Date sign | ed (Month | , Day, Year) |
| | | 1/100 | 1200 | 10 | 170udi | 7 | | 00 | 793 | | | Febru | LYU | 10,2000 |
| | 3 | 0. Neme and address of person | who completed | cause of d | eeth (Item 2) | 3a) (Type, | Print) | | | | | rebru | J | , |
| | 1 | bevin Foldman | MDHO | ecv M | edica | 1 | St Pau | IP | 1#4 | 07 7 | Bolt | | 212 | 02 |
| State | 3 | 1. Date filed (Mont); Pa BY eq | 4 2000 | 32. Registr | er s Signatur | | | | | | | ~ | - | |
| gistrar | | | | you | ers Signatur | _6 | | | | | | | | |
| Rev 6/95 | | | | | | | 191 | ac | 61 | | | | | |

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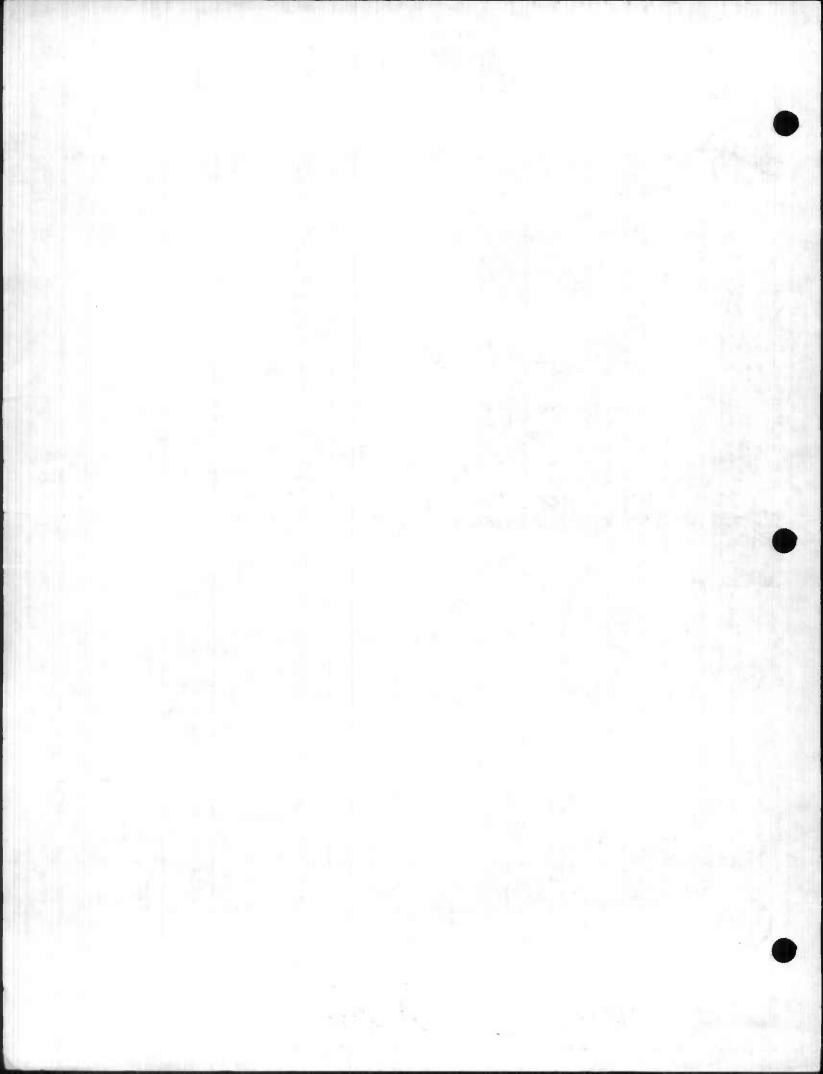
MICHAEL GOLDWATER

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|--|---|-----|----|-----|
| tate of Maryland / Department of Health and Mental Hygiene | U | 4. | JL | 1 |

| | 1. Decedent's Nam | ne (First, Middle, L | ast) | | | | | | 2. Date of Death | | Vest | 3. Time of | Desth |
|--|--|--|--|--|--|--|---|----------------------------|---|---|--|--|--------------------------------------|
| cian dical | Micha 4a Facility Name (| | | oodwat | er | | 4b. City, Tow | n, or Loc | Month JANUARY cation of Death | Day 22, 2 | Year 2000 of Death | 1155 | AM |
| iner | | ALESLEY I | | | | | BALT | | | | A | | |
| al er | 5. Sociel Security N 149-52- | Number 6. | Sex | 7. Age (In yrs. Ia 41 | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hours | 4 Hrs. Min. | 8. Date of Birth (Month, Day,) 12-08 | Year) | | place (State o | r Foreign |
| | Usual Residence of | 7 | | don City | T | | | | | | | 10d. Inside Cit | h . 1 ! !a . |
| 5 | MD | 10b. County | | | , Town or Loc | | | | | | | ¥≱Yes | |
| Director | 10e. Street and Nu | NA Imber | | ва. | ltimo | 101, Zip Code | | | 100 | g. Citizen of \ | What Cour | ntry? | |
| | | St. Pau | l Stre | et | | 21218 | | | | US | | | |
| by Funeral | 11. Marital Status 1 Never Marr 3 Widowed | ried 2 \ Married 4 □ Divorced | Armed Fo | 2 No | | /as Decedent of H Yes, specify Cuba | lispanic Origi an, Mexican, Specify: | in? (Spec Puerto P | cify Yes or No- Rican, etc.) | 14. Rac | ce - Americ ck, White, | | |
| Completed | /Spa | 15. Decedent's I | Education | | 16a. Deced | ent's Usual Occup | etion | of work in | 10 | 6b. Kind of B | usiness/In | idustry | |
| The same | Elementary/Seco | | College (1 | -4or 5+) | life. D | O NOT use retired | d) | J. HUIKIII | .8 | Van: | 0115 | trade | |
| | 12th G | | NA | | Lal | borer | 18 Mother | 's Name | (First, Middle, Me | | | crade | :5 |
| 0 00 | Dougl | | • | dwater | | | Car | | trust mone, m | | ell | | |
| = | 19a. Informant's N | | | | 19b. Mailing | g Address (Street | | | Route Number, | | | o Code) | |
| | Carol | Bell Go | odwate | r | | Charles | | | | | | | 5 |
| | 20a Method of Dis | | DB agravat to a | | ace of Dispos | sition (Neme of atory or other place | ce) | | Date 20 | Oc. Location - | City or To | own, State | |
| | | ☐ Cremation 3 5 ☐ Other (Spec | | State | ergre | en Ceme | tery | | | | | , NJ | |
| | 21. Signature of Fu | uneral Service Lic | ensee | 1 . 1 | | Name and Addre | | | | | - | | 202 |
| | 4.7 | Jalen | cia A | lollar | no WI | M.C.Mar | ch FH | 11 | 01 E. 1 | North | Ave | nue | |
| Н | 23a. Part1/Enter1 shock, or hee | the disease, or co ert failure. List on | mplications that cay one cause on e | aused the death. ach line. | . Do not ente | r the mode of dylr | ng, such as co | erdiac o | r respiratory arres | st, | | Approximate Interval Bet | ween |
| | | | | | | | | | | | | | Deeth |
| | Immediate Course | /Elnal | * | | | | | | | | | Onset and I | 1 |
| | Immediate Cause disease or condition resulting in death) | on | a. NAR | | | OHOL INT | OXICAT | TION | | | | Onset and t | |
| 15. | disease or condition | on | a. NAR | | ND ALC | | OXICAT | CION | | | | Onset and t | |
| animiet. | disease or condition resulting in death) | on | a. NAR | Due to (or | es a consequ | uence of): | OXICAT | CION | | | | Onset and t | |
| | disease or condition resulting in death) | on | a. <u>NAR</u> | Due to (or | | uence of): | OXICAT | CION | | | | Onset and t | |
| | disease or condition resulting in death) Sequentially list to if any, leeding to incause. Enter Under Cause (Disease or that initiated events) | onditions, mmediate erlying r injury is | a. <u>NAR</u> | Due to (or | es a consequ | uence of): | OXICAT | CION | | | | Onset and t | |
| edicai | disease or condition resulting in death) Sequentially list cold sny, leeding to in cause. Enter Unde Cause (Disease or Cause (Disease (Di | onditions, mmediate erlying r injury is | a. NAR | Due to (or | es a consequ as a consequ | uence of): | OXICAT | CION | | | | Onset and t | |
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| Physician/Medical | disease or condition resulting in death) Sequentially list confirm, leeding to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) | onditions, mmediate erlying r injury is Last | c | Due to (or Due to (or | as a consequal as a consequal | uence of): uence of): | | CION | 23b. Did tob | pacco use co s 2□ No | | | |
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| by Physiciary Medical | disease or condition resulting in death) Sequentially list confirm, leeding to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) | onditions, mmediate erlying r injury is Last | c | Due to (or Due to (or | as a consequal as a consequal | uence of): uence of): | | CION | 23b. Did tob | s 2□ No autopsy | 3 Pro | to the cause obbably 4 🗷 | Unknowr lindings |
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| cal Certification: To Be Completed by Physician/Medical Examiner | disease or condition resulting in death) Sequentially list condition of sny, leeding to incause. Enter Unde Cause (Disease or that initiated events resulting in death) Part It. Other significant of the exeminer? 27. Menner of Deat 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) | onditions, mediate eritying rinjury s Last filcant conditions th 9 ending investigati determine | Hospitel: d. Contributing to december C | Due to (or Due to (or Due to (or Due to (or Due to (or Path but not result of Injury h. Dey Year) of Injury - At hor ng, etc. (Specify, UND AT UND UND UND UND UND UND UND UND UND UND | as a consequence as a c | uence of): uence of): deriving ceuse give deriving ceuse give A 28c. Injury M 1 1 1 1 1 1 1 1 1 | 26. Place of the control of the con | of Death sing Hon 2 to 2 F | 23b. Did tob 1 Yes 24a. Was an perform 1 Yes (Check only one me XXResider 28d. Describe how UNKNO) 281. Location (Str. City or Town, BALTIMOR) and due to the cell | autopsy ed? s 2 No s) noe 6 X Oth w injury occur WN eet and Numit State) 16 E, MD use(s) and m | 3 Pro 24b. W sc of 14 14 ber or Rurred 0 3 HA | lo the cause of obably 4 12 Vere autopsy invaliable prior to original from the cause of the caus | Pinknown lindings o ause No |
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| edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list condition of sny, leeding to incause. Enter Unde Cause (Disease or that initiated events resulting in death) Part It. Other significant of the exeminer? 27. Menner of Deat 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) | onditions, mmediate eriying rinjury is Last filcant conditions filcant conditions filcant conditions investigation of could not determine | Hospitel: d. Contributing to december C | Due to (or Due to (or Due to (or Due to (or Due to (or Path but not result of Injury h. Dey Year) of Injury - At hor ng, etc. (Specify, UND AT UND UND UND UND UND UND UND UND UND UND | as a consequence as a c | derlying ceuse given the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of t | 26. Place of the property at | of Death sing Hon 2 to 2 F | 23b. Did tob 1 Yes 24a. Was an perform 1 Yes (Check only one me XXResider 28d. Describe how UNKNO) 28l. Location (Stractive or Town, BALTIMOR) and due to the ceud at the time, dat 29 | autopsy ed? s 2 No s) noe 6 X Oth w injury occur WN eet and Numit State) 16 E, MD use(s) and m | 24b. Washington of the control of th | lo the cause of th | Pinknown lindings o ause No |

Registrar

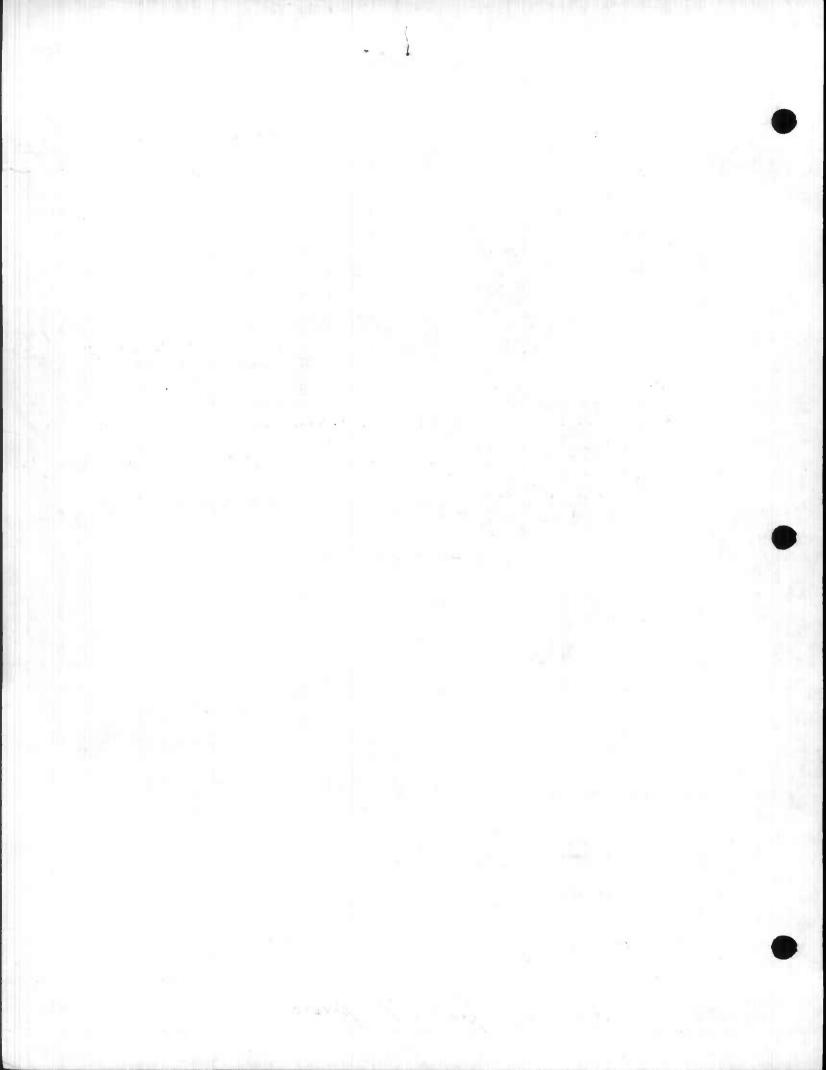
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

04349 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 9:01am Leroy Hollie 2 8 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2111 Cliftwood Ave Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1QM 2□ F Hours Months 251-42-6160 70 Director SC 12-09-29 Usual Residence of Decedent deeth with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examinar must be notified at MD NA Baltimore 1- Yas 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 2111 Cliftwood Avenue 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 72 hours efter IV Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hyglens important: if item 27 is marked other the eny injury or other treumstic event, that pages. Laborer Bethlehem Steel Co. 8th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) Julius Hollie Louise Durdee 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) Mary Hollie 2111 Cliftwood Avenue Baltimore, Maryland 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥ŒBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) Crownsville VA Cem. 02-14-2000 Crownsville, MD. 22. Nama and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses Julya 1101 E. North Ave. Ma March F. H. East 23a. Part1. Enter the disease, or complications that shock, or heart feiture. List only one cause on a ed the death. Do not entar tha mode of dying, such as cardiac or respiretory arrest, Onset and Death **Physician** /Medical Immediate Causa (Finet disease or condition resulting in death) -ungent Examiner Due to (or as a consequence of): Examiner ettending physician end for use es the burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 6 Records, by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed + hse 1 Yes 2 No 1 ☐ Yes certificete of Vitai Physicien: 8 25. Was cese refarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 1□ Yes 2☑ No 2 5 Residence 6 Other (Specify) · this To the Hospital or Attending Pt within 24 hours effer deeth.
To the Funerel Director: Affer the completely filled in by the funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Netural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

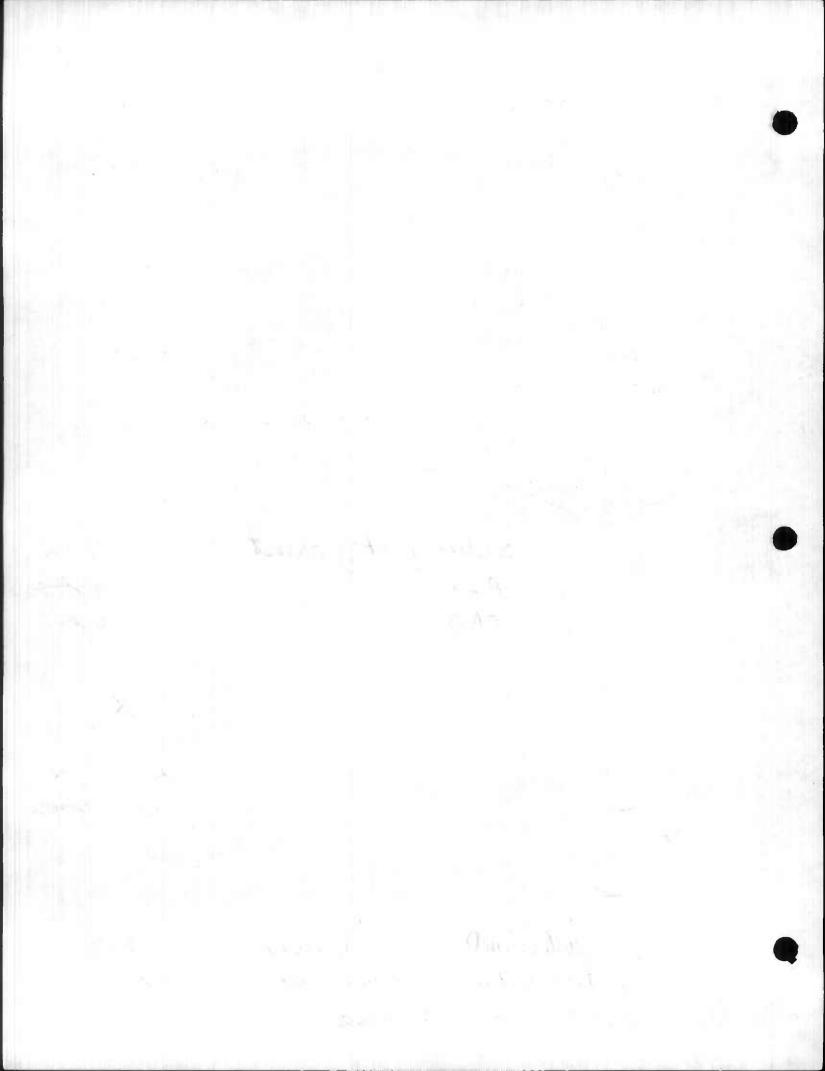
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie My 11 00 M 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Bultimer 21202 54 301 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



ORIGINAL

nichae,

State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. 04351 State of Maryland / Department of Health and Mental Hygiene amend item 17,18 per fh G781 3/10/00 yg AMENDEO ITEM # 8 PER FH G7780 2/14/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 9. Month D FEBRUARY **Physician** Toy Mai Hom 2000 08:00AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth, 12/12/09 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X F Hours 219-32-0991 90 Yrs. Director China Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom mant be notified at Baltimore Maryland Reisterstown 1 ☐ Yas 2 No Directo 288-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? b 71 Shetland Cir. 21136 23. United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZXNo If Yes, Give Year or Detes: Heme Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Bleck, White, atc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Asian natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cleaning service employee Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Pages 1 and 2 should be filt ment of Health and Mental H ant: If Itam 27 Is marked oth Be Lui Yun Yang -unknown Toy Lim Sun, - unknown unknown 2 unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: if Item 27 is any Injury or other trau Benjamin Yep/son Silver Spring, MD 11403 Encore Dr. 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery 2/14/00 | Woodlawn, Maryland 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funerel Service Licensee 6500 York Rd 21212 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Approximete** Intervel Between Onset and Death **Physician** CARDIOMYOPATHY /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and Due to (or es a consequence of): Box 68760, physician Physician/Medical Due to (or as a consequence of): 080 signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Peen has page 2 2 No 1 Yes 1 ☐ Yes 2 No this certificate Physician; 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitet: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 21 No Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? After Attending Neturel 5 Pending investigation To the Hospital or asset within 24 hours after death.
To the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as stated. 29a. Certifier Medical On the busin of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce 29c. License number 29d. Dete signed (Month, Dey, Year) D45475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD R. RAHNAMA, M. D., 17 FONTANA LANE, S-105, BALTIMORE, MD. 21237

DHMH 16 Rev 6/95

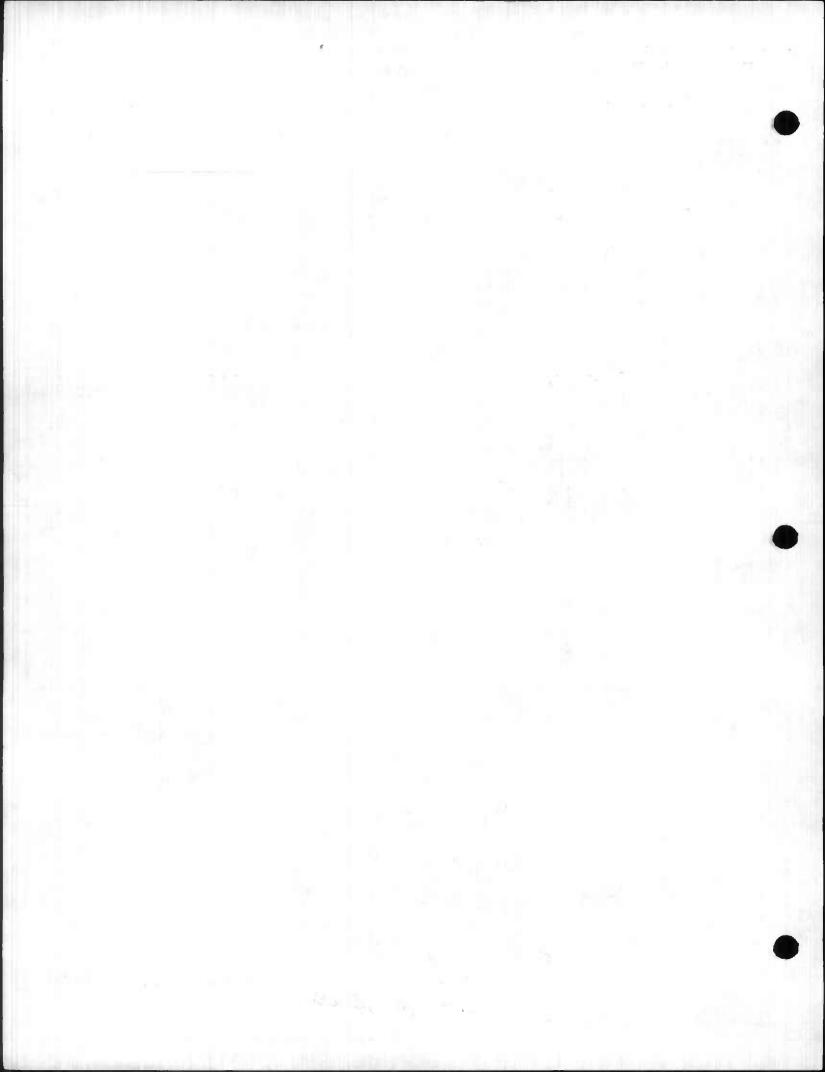
State Registrar 31. Date filed (Month, Day, Year)

FEB 1

32. Registrer's Signature

2000

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04352 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Year Month **Physician** 7:35 P.M ALICE HOLLOMAN 2000 February /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A TONes eA MANCARE imore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 12, 1916 If Under 1 Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🖾 F unknown 243-28-4190 83 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Baltimore Director MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 1525 N. Ellamont Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Bleck, White, etc. 11 Mental Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Introcramt: if Nem 27 is marked other than "natural", or item any injury or other traumatic event, traumatic event, and page 1 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: black by 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St Agnes Hospital 900 S. Caton Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Funeral Service Licensee Joseph B, Van 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical · Chronic Imprary Visease Examiner Due to (or as a consequence of): Physician/Medical Examiner Sep513 attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? zheimers Dementio 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 24 hours after death. 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a Certifier

Vital

21215-0020

Baltimore, Maryland

Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year) State

100

29b. Signeture and title of certifier

ORIGINAL

M.D.

90

32. Registrar's Signature

000

2000

FEB14

05

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year) 29c. License number

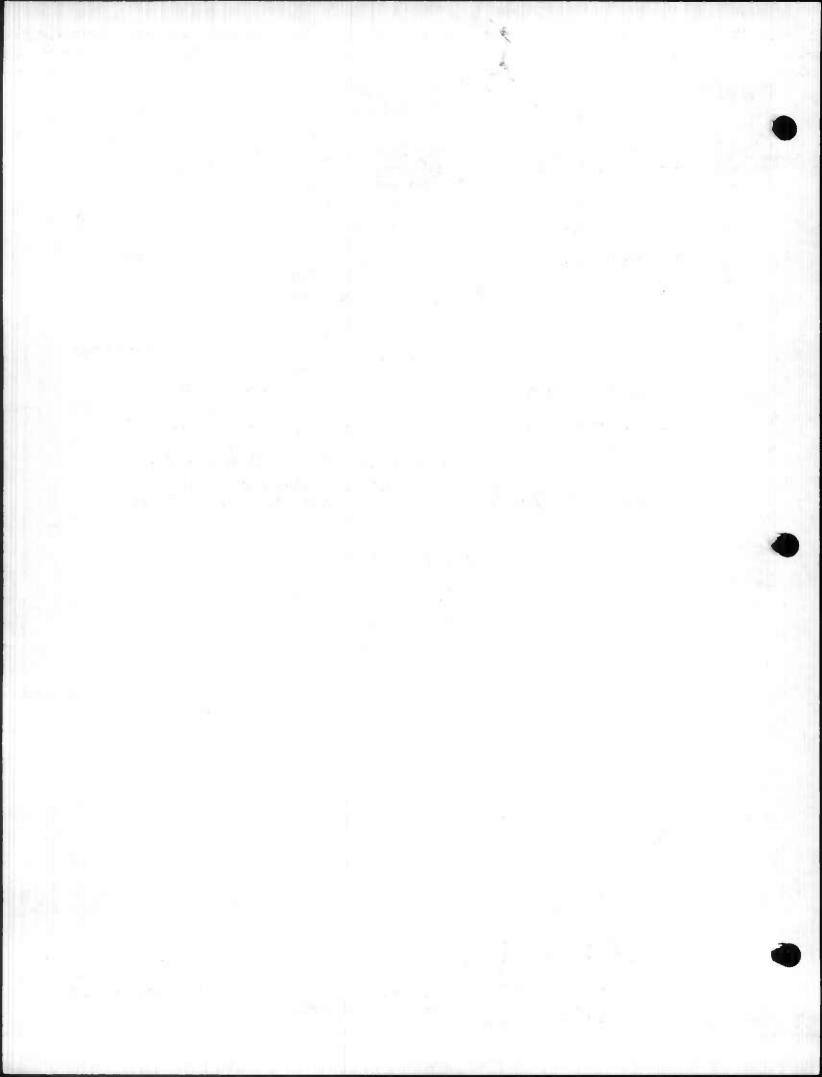
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 0 4 3 5 3
State of Maryland / Department of Health and Mental Hygiene

| | | | | | Certifica | te of | Death | | Reg. No. | | |
|---|---------------------|---|--|--|-----------------------|---|---|---|--------------------------------|------------------------------|---|
| Physici /Medic | al | Decedent's Neme (First, Middle, La | rey | W_i | John | son | 4b. City, Town, or I | 2. Dete of Do Month 52 | Dey 10 | Yeer 2000 nty of Death | 3. Time of Deeth 3.15 p. m |
| Examir | ier | Bon | Sec | | Milan | 1 Vaa- | Baltin | noire | | NA | |
| uneral irector | | 217 70 1200 | THE OFF | (In yrs. lest | Yrs. Month | er 1 Yeer S Days | | 8. Dete of Bi | Y956 | 9. Birthp | place (State or Foreign |
| show | Ļ | Usuet Residence of Decedent 10a. Stete 10b. County | | 10c. City, T | own or Location | | | | | 1 | 10d. Inside City Limits |
| or 28a-f show | Director | MD N/A 10e. Street end Number | | | BALTIMO 10f. Z | RE ip Code | | | 10g. Citlzen | of Whet Cou | 1 Yes 2 No |
| ma 23a (| Funeral D | 3501 EDGEWOOD ROA | 12. Was Decedent E | ver in U.S. | 13. Wes Dec | | 1215 Hispenic Origin? (Si | pecify Yes or N | D- 14, F | USA Rece - Americ | can Indian. |
| al', or items 23a or 28a-f show Examiner must be notified at | þ | 1 Never Merried 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: | 0 | If Yes, sp 1 ☐ Yes | | | rto Rican, etc.) Ble | | Bleck, White, | |
| r than "natural", tre Medical Exi | Be Completed | 15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12) | de completed) | Cottege (1-4or 5+) (Give kindlife. DO | | nt's Usuel Occupation nd of work done during most of working D NOT use retired) | | | 16b. Kind of Businass/Industr | | |
| d other t event, th | 3e Co | 17. Fether's Neme (First, Middle, Last) | | | CARPENTE | R | 18. Mother's Nen | ne (First, Middle | | | ,I ION |
| 27 is marked other than or traumatic event, the M | To | GEORGE E. JOHN 19e. Informent's Neme/Relationship (| | | 19h Meiling Addre | ss (Stree | | HILDA PROCTOR There or Rurel Route Number, City or Town, Stete, Zip Code | | | a Code) |
| E | | JILL J. BELL/SIS | rer | 20b. Pleci | | ON_R | OAD, SYKE | | MD 21 | | |
| | | 1 Burial 2 Cremetion 3 Donetion 5 Other (Specif | 1) | | CRO CREMA | TORY | | 2/11/2000 | BALTO. | | |
| Important: i any injury o | | 21. Signature of Funerel Service Licer | Morton | | | | MORTON & RENS ST. | SONS F. BALTO. | | | |
| attanding physician and and for use as the burel-transit | an/Medical Examiner | Immediate Cause (Finet disease or condition resulting in death) Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | b | PN Due to (or es | e consequence of | 0 ~ | i A | | | | |
| ached | Physician/ | Peri II. Other eignificant conditions of | ontributing to death but | not resultin | g in the underlying | ceuse g | iven in Pert I. | | tobacco uae | | o the cause of death |
| s been signed 2 should be da | Completed by P | | | | | | | 24a. Wes | en eutopsy ormed? | 24b. W | ere autopsy findings relieble prior to empletion of cause deeth? |
| cartificata ha | | 25. Wes case referred to medical | | | | | | 10 | | 10 | □Yas 2□No |
| 60 G | To Be | exeminer? | Hospital: | t 2 ER | Outpetient 3 2 | OOA Ot | 26. Ptece of Dea ther: 4 \(\sum \) Nursing H | ome 5 Res | | Other (Specia | (y) |
| octor: Aftar thi by the funeral | Certification: | 27. Menner of Deeth 1 Auturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | | | D. Time of Injury M | | Yes 2□No | 28d. Describe | | | el Route Number. |
| To the Funeral Director: complataly filled in by tha | | 4 Homicide determined 29e. Certifier Certifying Ph | building, etc. | (Specify) | | | | | wn, Stete) | manner as s | steted. |
| o the Fu | Medical | (Check only 2 Madical Exam | Inar: On the basis of e end menner stet | examinetion | end/or investigetion | n, in my | opinion, deeth occu | rred et the time | date end pled 29d. Dete sig | e, and due to | o the cause(s) |
| -0 | | · Edwall | Alber S |)_ | 5 | D45 | 1430 OLD con | | | | |
| 1 | - 1 | 30. Name end eddress of person who | | | | | | | | | |

DHMH 16 Rev 6/95



Please Type of Print In Black Indelible Ink. Assure All Copies Are Legible.

JAMES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

1√2 Yes 2 No

| JA | CKSON | |
|----|----------|---|
| | Physicia | r |

1. Decedent's Name (First, Middle, Last)

2. Date of Deeth

| Physician |
|-----------|
| /Medical |
| Examiner |

JAMES F. JACKSON 4e Facility Name (If not institution, give street end number)

JANUARY JANUARY 4b. City, Town, or Location of Death 17,2000 1:50P.M. 4c. County of Death

Funeral

9. Birthplace (State or Foreign Country).
White

Director

or 28a-f show the Medical Examiner must be notified at Herna 23a filed within 72 hours after death natural, or

al Hygiene. Pages 1 and 2 should be nent of Health and Mental Department of Health a Important: If Item 27 Is any Injury or other training

Maryland 21215-0020

Baltimore,

Physician /Medical Examiner

Physician/Medical Examine The law requires that the death certificate be executed and been signed by the attending physician should be detached for use as the buria Box 68760. P.O. Division of Vital Records. g After this certificate has been si funeral director, page 2 should I Completed al or Attending Physician: The safter death.

A Director: After this certificate of in by the funeral director, pa Be Medical Certification: filled in by To the Hospital within 24 hours a To the Funeral D completely filled

13913 CASTLE BLVD SILVER SPRING MONTGOMERY Honder 1 Year Hours Min. Solution 1928 5. Social Security Number 7. Age (In yrs. last birthdey) Yrs. 71 unknown Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 13913 Castle Blvd #12 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Yeer or Detes: unknown 1 Never Merried 2 Merried 1 Yes 2 No Specify: white g 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) In State 22. Name end Address of Fecility Joseph B. Van State Anatomy Board 655 W. Baltimore Street 1101 Baltimore, MD 21201 23a. Part1. Emer the d cations that caused the dieth. Do not enter the mode of dying, such as cardiec or respiretory errest, Immediate Cause (Finel a Atheroscleratic cardiovascular disease and disease or condition resulting in death) Due to (or es e consequence of): lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of)

| ert II. | Other significant | t conditions contribu | uting to death but r | not resulting In | The underlying cause g | ven in Pert |
|---------|-------------------|-----------------------|----------------------|------------------|------------------------|-------------|
| | | | | | | |

23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

24b. Were eutopsy tindings aveileble prior to completion of cause of death?

Approximete Intervel Between Onset end Death

1 X Yes 2 □ No 26. Plece of Deeth (Check only one)

| 1 XYes | 2 No | |
|--------|------|--|
| | | |

| examiner? |] No |
|-------------------|--------|
| 27. Manner of Dea | |
| 1 Netural | 5 □ Pe |
| 2 Accident | inv |

3 Suicide

25. Wes case referred to medical

5 Pending investigation 6 Could not be

Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture and title of certified

O.C.M.E.

29c. License number

29d. Dete signed (Month, Day, Year) JANUARY 18,2000

Location (Street end Number or Rural Route Number, City or Town, Stete)

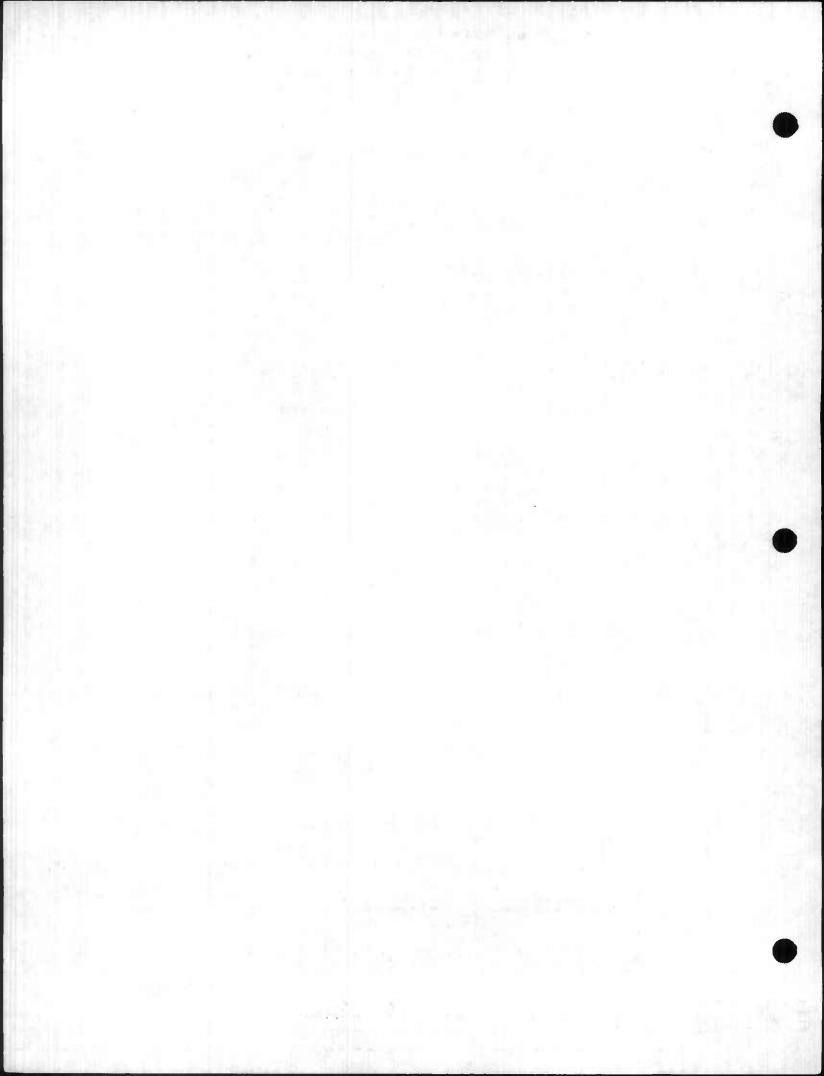
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Radentz phen 31. Dete filed (Month, Day, Year)

32. Registrar's Signature Genera

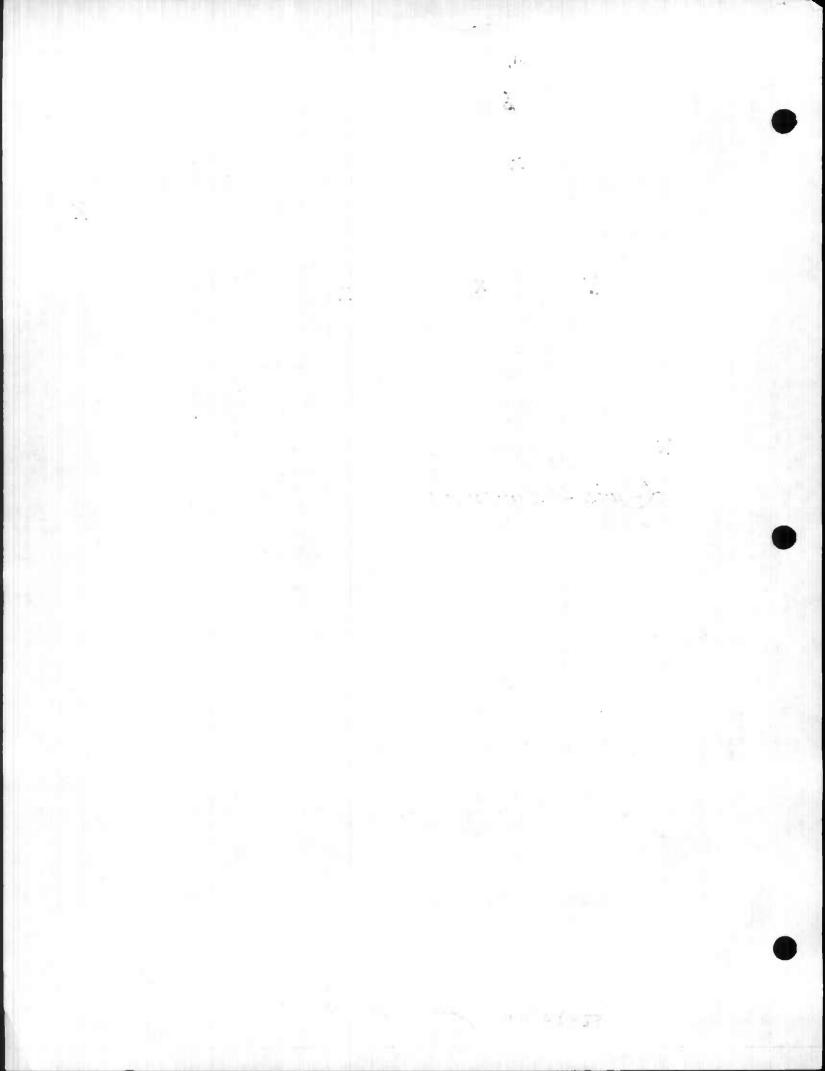
111 Penn Street, Baltimore, Maryland 21201

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | Otato of Maryland / | Certificate of Death | Reg. No. 00 04355 |
|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIRGINIA B KNIGH 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Dea | Day Year 3. Time of Death |
| Funeral Director | 5. Sociel Security Number 6. Sex 7. Age (In yrs. last bi | irthday) If Under 1 Year If Under 24 Hrs. 8. Dete of 8 Months Days Hours Min. (Month, D | N BALTIMENO |
| aryland show | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | | 10d. Inside City Limits |
| vith the Mer or 28a-1 a be notified | MD. N/A BAL | TIMORE | |
| th with the Merylar 23a or 28a-f show ust be retired at ral Director | 10e. Street and Number 4003 W. FOREST PARK AVENUE | 10f. Zip Code | 10g. Citizen of What Country? |
| r heme 234 directment | 4003 W. FOREST PARK AVENUE 11. Marital Status 12. Wes Decedent Ever in U.S. | 21207 | U.S. OF A. |
| al', or hems | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Detas: | Wes Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify: | Bleck, White, etc. Specify: BLACK |
| led within 72 hours after death with the Menyland Vgjene. Ner than "natural", or items 23s or 28s-f show nt. the tradest Exemination must be notified at Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN 16a College (1-4or 5+) UNKNOWN | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| BEST O | UNKNOWN UNKNOWN | HOME MAKER 18. Mother's Name (First, Middle | le Maidea Sumama) |
| Saby W | 17. Father's Neme (First, Middle, Last) | | |
| 2 should is and Menils merkersumetics | 10a Informantia Nama/Deletionahia /Time Brieft | VIRGINIA MA b. Meiling Address (Street end Number or Rurel Route Num | |
| and 2 sealth ar n 27 le | CARL J. KNIGHTON (BROTHER | | O., MD. 21215 |
| of Her vota | 20a. Method of Disposition 20b. Pleas of cemeter | of Disposition (Nama of pry, cremetory or other plece) / 18/2000 Pate SON FOREST VET. CEM. | 20c. Location - City or Town, State BALT OWINGS MILLS, MD. |
| permit. Pag Department Important: I eny Injury o | 21. Signetury of Fiberel Sarvice Licensee LiWIS T. GWY | 4517 PARK HEIGHTS A | |
| Physician | Immediate Cause (Finat disease or condition resulting in death) Due to (or es e | A . | Onset and Death |
| certificate be executed ving physician and use es the burial-transit | Cause (Diseese or Injury | consequence of): | |
| death certi e attending ed for use sician/M | Part ii. Other significant conditions contributing to death but not resulting | In the underlying cause given in Part I 29h Dir | d tobacco use contribute to the cause of death |
| d by the letache | END CTAGE RENAL DIE | | Yes 2 No 3 Probably 4 Hunknow |
| sw requires been 2 should | PONEPHENAL VASCULAR Di | SCASE, STATES 24a. Wa | 24b. Were autopsy findings available prior to completion of cause of death? |
| ystclan: The la s certificate ha director, page To Be Com | 25. Was case referred to medical | Bypers AND Gray 10 26. Place of Death (Check only | Yes 2010 1 Yes 2010 |
| To To | 1 ☐ Yes 2 ☐ 1 ☐ Hospitel: 1 ☐ Inpatiant 2 ☐ ER/O. 27. Menner of Ceath 28a. Dete of Injury 28b. | | sidence 8 Other (Specify) a how injury occurred |
| | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, for building, etc. (Specify) | erm, street, fectory, office 28f. Location City or To | (Street end Number or Rural Route Number, own, State) |
| To the Hospital or within 24 hours after To the Funeral Director Completely filled in Medical Cert | | e, deeth occurred et the time, dete end place, and due to the nd/or investigation, in my opinion, deeth occurred at the time | |
| To the complete | 29b. Signature and title of cariffier hug | 29c. License number 29c. 20c. License number | 29d. Date signed (Month, Day, Year) FEBRUARY (1, 2000 |
| 4 | 30. Name and address of person who completed cause of death (Item 23a) | (Type, Print) NonTHOUSET | FEBRUARY 11, 2000 HOSPITAL CONTAR MIL 21133 |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registrer's Signeture | a B sports | 11135 |



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

| 355-013 | | | | Department of Certificate of | | | Reg. No. | 04356 | |
|--|---|--|--|---|---|--|---|--|--|
| Physician /Medical | 1. Decedent's Neme (First, Mid Charle | | 2. Date of Death Month Day Year FEBRUARY 11, 2000 0812 AM | | | | | | |
| Examiner | 4a Facility Name (If not institute CARROLL COUNT | | WESTMIN | | | RROLL | | | |
| Funeral Director | 219-36-0971 XXM 20F | | EO | Age (In yrs. last birthday) Yrs. If Under 1 Year Months Days | | 8. Date of Birth | Birth Year 940 9. Birthplace (State Mary Pand | | |
| | Usual Residence of Decedent 10a. State 10b. Coun Md. Carr | • | | 10c. City, Town or Location New Windsor | | | 10d. Inside City Limi | | |
| ise death with the Maryland heims 23a or 28a-f show her must be notified at unnersi Director | 10e. Street and Number 3205 Ha | | 10f. Zip Code | 1776 | | | What Country? | | |
| ar, or he Examine by Fur | 11. Meritel Stetus 1 Never Married 2 Merited 3 Widowed 4 Divorce | leni Ever in U.S. ces? 2 No 1958— les: 1964 | 13. Was Decedent of If Yes, specify Cu | dispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| within 72 han 'nat is Medica mplete | 15. Decede (Specify only high Elementary/Secondary (0-12) | 16a. | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | | | 16b. Kind of Business/Industry Real Estate | | | |
| B even | 17. Father's Name (First, Middle Maurice L | | Salesman | | (First, Middle, Meiden Sumame) Ruth Jackson | | | | |
| and 2 should saith and Mor s 27 is marks ar traumatic | 19a. Informant'a Name/Relation Barbara Ann L | | | | | mber or Rural Route Number, City or Town, State, Zip Code) Rd., New Windsor, Md. 21776 | | | |
| Pages 1 a hard of He int: If Nam iny or othe | 20a. Method of Disposition 1 | | tate cemete | Place of Disposition (Name of cemetery, cremetery or other place) ruid Ridge Cem. Feb. 15. | | | 20c. Location - City or Town, State Pikesville, Md. | | |
| Cate be executed hysician and the burist-fransit the burist-fransit cate Examiner dical Examiner | 23a. Part1. Enter the disease, shock, or heart failure. LI Immediata Cause (Final disease or condition resulting in death) Sequentielly list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | st only one cause on ee | a Static Due to (or as e | Lung (consequence of): | | ac or respiratory en | rest, | Approximate Interval Between Onset and Death | |
| death certification of the second of the sec | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Perforated duodenal UICEC 1 Yes 2 No 3 Probably | | | | | | | ntribute to the cause of death 3 Probably 4 Ohknow | |
| has been s ge 2 should mpieted | Atherosclero | io vascula | vascular Disease | | | an autopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| Physician: The this certificate ral director, pag. To Be Co | 25. Wes case referred to medic examiner? | 100000000000000000000000000000000000000 | | | 26. Place of D | eath (Check only o | - 10 | 2010 | |
| 를 를 다 | XXYes 2□ No | | patient XXER/Ou | tpatient 3 DOA | | 1 | ☐ Residence 6 ☐ Other (Specify) | | |
| solution Attending nours after death. neral Director: After y filled in by the fune al Certification | 3 Suicide 6 Could deter | d not be mined 28e. Place o building | 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ce, and due to the cause(s) and menner as stated. | | | | | | |
| To the Hospi within 24 hou To the Funer completely fill | 29b. Signature and little of certif | and manner | Lad | 29c. Licer | ise number | I | 29d. Date signe EBRUAR | and due to the cause(s) Id (Month, Day, Year) Z 12, 2000 | |

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Registrar

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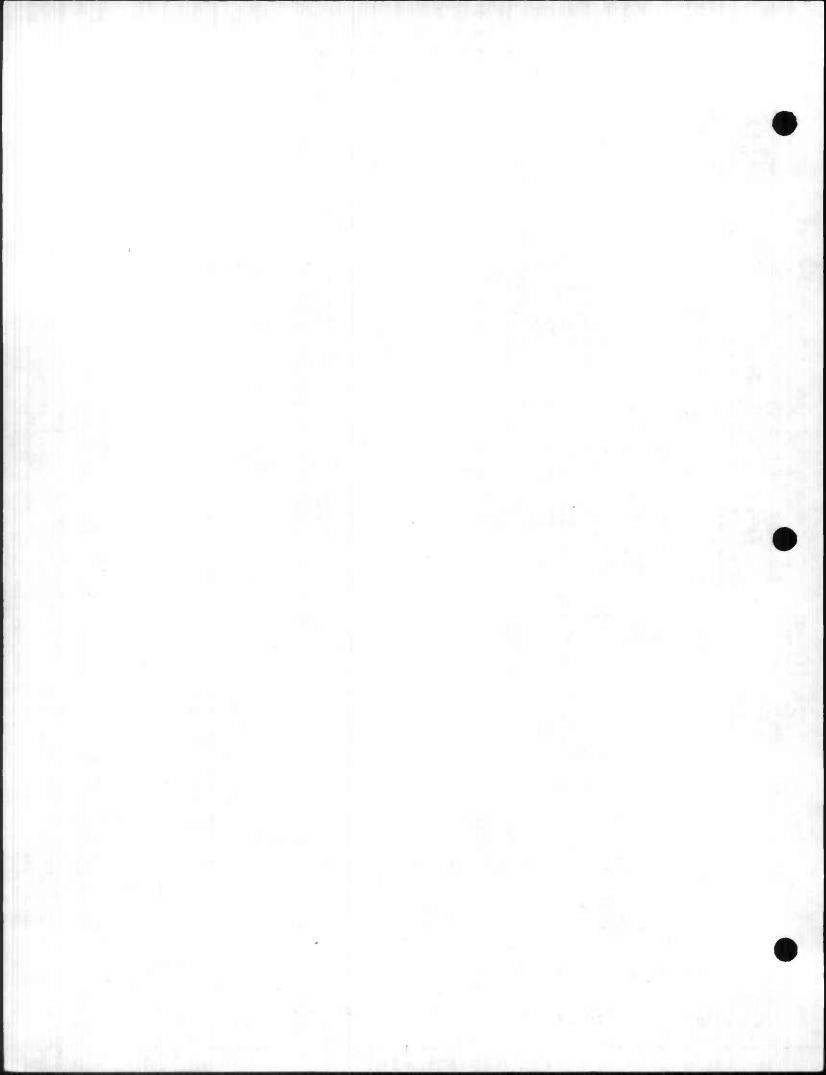
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 14357

| | | | Certifica | te of Death | | Reg. No. | 0 40 | 101 | |
|--|---|--|--|--|---|---|--|---|--|
| Physician | 1. Decedent's Nama (First, Middla, Las | " Lako | | | 2. Data of De Month | Day M | Year / | Time of Death | |
| /Medical Examiner | 4a Facility Neme (If not Institution, give | street and number) | Λ | 4b. City, Town, or | Location of Deat | h Ac. County | of Death | 13/11/ | |
| | 5. Social Security Number 6. Se | atayette | Aue. | ler 1 Year If Under 24 Hr | imore | | MA | Ctata as Familia | |
| Funeral Director | | ex | Yrs. Month | | | 5,1919 | Country (| Carolin | |
| the Marylan 28e-f ahow notified at | Maryland 10b. County | A 10c. C | Baltim | ore | | | | side City Limits Yas 2 No | |
| th with the Mai | 10e. Street and Number 2630 W. La | fayette; | Ave. 101.2 | 21216 | | 10g. Citizen of V | What Country? | | |
| 72 hours after death with the Maryland natural, or items 23a or 28a-f show deal Examiner mans be correct as sted by Funeral Director | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: | | pedent of Hispanic Origin? (pecify Cuban, Mexican, Pue | Specify Yas or No rto Rican, atc.) | Specify | e - American Inc ck, Whita, etc. | fian, | |
| natural, | 15. Decedent's Ed (Specify only highest grad | ucation de completed) | 16a. Decedent's Us (Give kind of | sual Occupation work done during most of wi use retired) | orking | 16b. Kind of B | usinass/Industry | 4 | |
| withir shan | Elementary/Secondary (0-12) | College (1-4or 5+) | IIIa, DO NOT | use retired) | | Pri | Vate | | |
| be filed tai Hygie event, Be Co | | . 11 | 1 7 001 | 18. Mother's Na | ame (First, Middle | , Maiden Suman | 10) | | |
| 2 should be and Mentai is marked or sumatic ev | William SI | nith | 1 404 44-11 444 | Car | oline | Sm | uth | | |
| | 19a. Informant's Neme/Raiationship (7 | upo, Print) (Husband | 2630 1 | ss (Street and Number or F | te. Alle | De H | N. M. | 2/2/6 | |
| nemit. Pages 1 and 3 Department of Health reportant: If them 27 I ny Injury or other tri MGB. | 20e. Mathod of Disposition 1. Buriai 2 Cremation 3 | | Place of Disposition (A cematary, crematory o | lame of r other place) | Date | 20c. Location - | City or Town, S | State | |
| emit. Pag epartment mportant: In ny Injury o | 4 □ Donation 5 □ Other (Specify | 6 | arrisor | 1 Forest | 916/2000 | Owing | s Mills | s, Md. | |
| permit. Pa Department Important: any Injury page. | 21. Signature of Funaral Service (Cons | L. Ru | 15 222 | and Address of Facility Ph L. RUSS 2 W. North | Funer Ave. | Balto. | ne Md. 21 | 216 | |
| | 23a. Part 1/ Entar the disease, or comp shock, or haart failure. List only of | olications that caused the dea one cause on each line. | th. Do not entar tha m | ode of dying, such as cardio | ec or respiretory a | rrest, | Appr Intan Onse | roximate val Between et and Death | |
| Physician /Medical | Immediate Cause (Final disease or condition as SARCOMA 5.5 MO | | | | | | | | |
| Examiner | rasulting in death) | | or es e consequence o | ŋ: | | 100 | 1310 | 1110 | |
| axecuted in and ial-transit Examiner | | b | | Α. | | | 1 | | |
| sate be axecuted thysician and the burial-transit dical Examir | | | | | | | | | |
| 2 4 6 | Cause (Disaasa or injury that initiated events resulting in death) Last Dua to (or es e consequence of): | | | | | | | | |
| attending for use a: Clan/Me | | d | | | | | 1 | | |
| a death he atte hed for hed for | Part il. Other significant conditions co | entributing to death but not re- | sulting in the underlying | in the underlying cause given in Part I. 23b. | | | Did tobacco use contribute to the cause of death | | |
| ed by the detach | | | 10 | Yss 2□ No | 3 Probably | 1 Unknow | | | |
| The law requires that the death certains been signed by the attendir page 2 should be detached for use Completed by Physician/A | | 24e. Wes | en autopsy ormed? | available | utopsy findings a prior to ion of cause | | | | |
| within 24 hours after death. To the Funeral Director: After this certificata has the properties of the funeral director, page 2 semple test of the funeral director, page 2 semple filed in by the funeral director, page 2 semple filed in Certification: To Be Complement | | | | | 10 | Yas No | 1 ☐ Yas | 2 □ No | |
| | 25. Was casa rafarrad to medical axeminar? | 26. Placa of Death (Check only ona) Hospital: Other: Othe | | | | | | | |
| Physician: r this certific aral director, 7: To Be (| TE TAS ZESCHO | 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hom | | | | ne 5A Residence 6 Other (Specify) 28d. Describe how injury occurred | | | |
| Attending in death. Sector: After funding by the funding iffication | 1 Natural 5 Pending 2 Accident Invastigation | M 1 Yes 2 No | | | | | | | |
| To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to the funeral properties in the funeral Medical Certification: | 3 Suicide 6 Could not be datarmined | 286, Place of Injury - At nome, farm, street, factory, drice | | | | ion (Street and Number or Rural Route Number, or Town, Stata) | | | |
| Hospital 24 hours Funeral stely filled | 29a. Certifier Cortifying Phy (Check only 2 Medical Exam | relcian: To the best of my kno iner: On the basis of examine | owledge, death occurre | d at the time, date end place on, in my opinion, death occ | e, and dua to the curred at the time, | cause(s) and madete and plece, | anner as stated. and due to tha c | cause(s) | |
| To the To the Mention 2 | 20h Signatura and titland contillet | | | | | | | | |
| F3F | 1 Sull | | 2/7/2000 more MO 2/20/ | | | | | | |
| VIO | 30. Nama and addrass of person who c | ompleted causa of death (Ite | m 23a) (Type, Print) | 11 10 1 | 10 | 1A A A | 0: | , | |
| 0 1 | ANDREW Kenne 31. Date filed (Month, Day, Year) | 22 S | · Greens | St, Bal | more | 1110 | 2/20/ | , | |
| State Registrar | TED 1 A | 32. Registrar's Sign | Sar B | Souks | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04358 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#10g perFH G780 2/14/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. **Physician** 2000 5:30 pm MUNIR MIAN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore N/A University of Maryland Medical System 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Wrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□ F 219-76-3278 3-15-1952 Director Pakistan Usual Residence of Deceden 10a. State x 28a-f show a notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director Md N/A Baltimore \$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 of 2 should be filed within 72 hours after death with hand Mental Hygiene.
7 Is marked other than "natural", or itema 23a or transfer ownt, the Media Estation man be transmissed ownthing the Media Estation. 1244 Light Street U S A PAKISTAN 21230 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritai Stetus Biack, White, etc. 1 ☐ Yes 3 ☐ (No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ₺ Worced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Pizza Hut of Md Inc. N/A 17. Father's Neme (First, Middle, Last) General Manager permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If hem 27 is marked other
any injury or other traumests 18. Mother's Name (First, Middle, Meiden Sumame) Be Mian Bashir Ahmed Manzoor Fatima 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6656 Seneca Dr., Columbia Md 21046 Rashid Shakir-Brother 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2-11-00 Randallstown, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ad March F/H West RC warme w 4300 Wabash Avenue Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 2 Weeks Sepsis Examiner Due to (or as a consequence of): 2 Weeks Pneumonia Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and physician certificate be Physician/Medical that initiated events resulting in death) Last the Due to (or as a consequence of) 98 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably 4 Unknown Coronary Arter Disease by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Ischemic Cardiomyopathy page 2 has 1XYes 2□ No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred e Hospital or Attending P n 24 hours after death. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation Neturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide

Box 68760. P.0. Division of Vital Records. To the Hosp within 24 ho To the Fune completely fi

Maryland 21215-0020

Baltimore,

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State Registrar

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29a. Certifier

(Check only one)

290. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrade Signature 4 2000 Denewa

30 Name and address of person who completed cause of death (Nem 23a) (Type, Print)

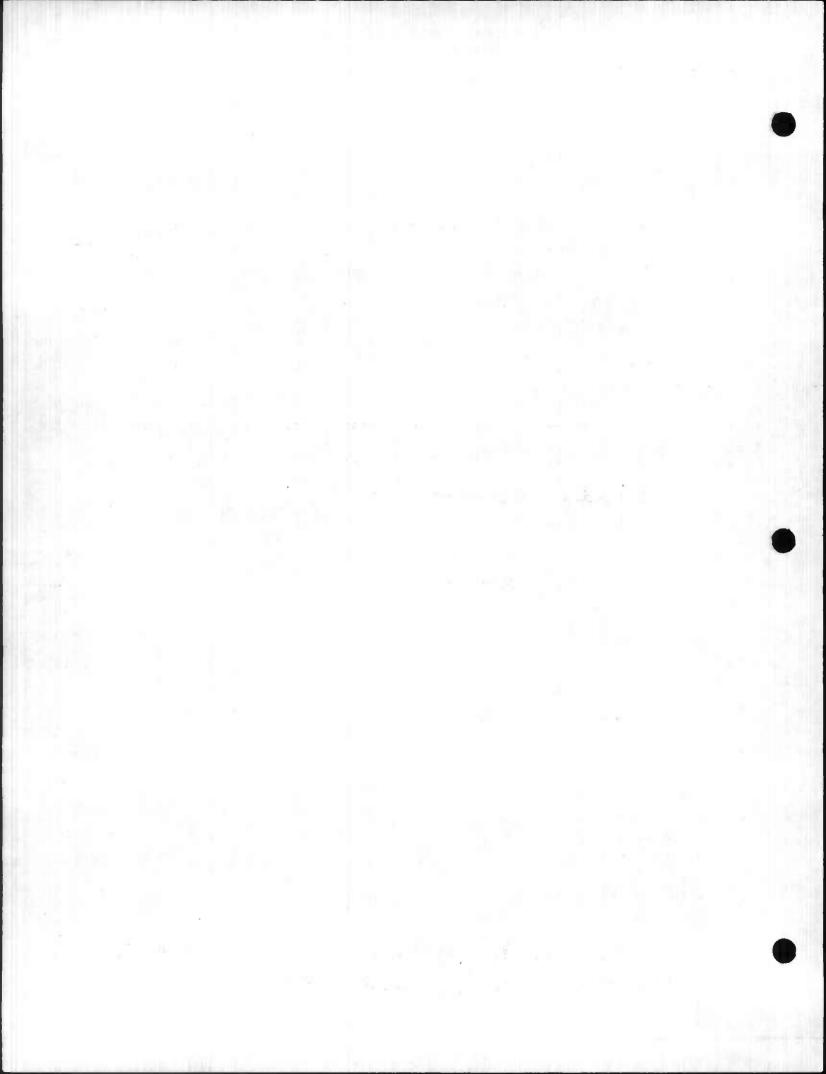
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1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

P13369

29d. Date signed (Month, Day, Year)



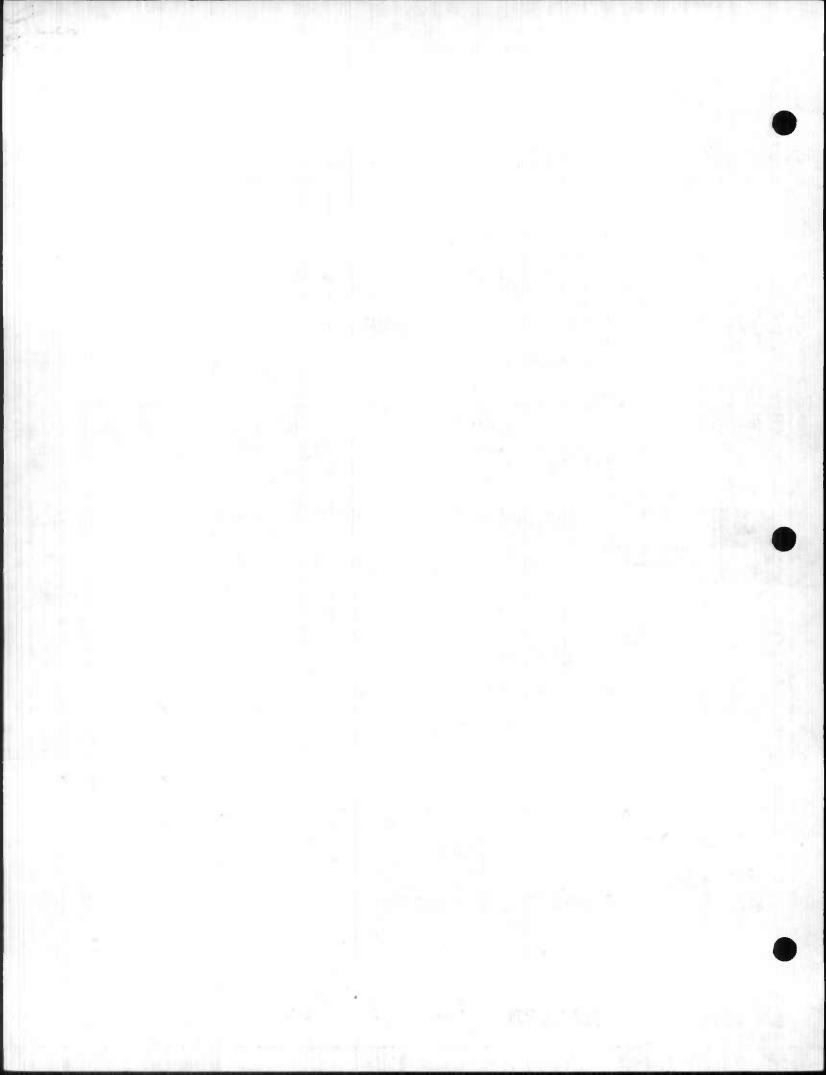
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State of Maryland / Department of Health and Mental Hygiene 04359 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ames 17, 2000 4c. County of Death tebruary /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner irnwoo MUnder 24 Hrs. | 8, Dete of Bir 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 9. Bitthplaca (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 22-119: 1)0 M 20 F Months Days Hours Min. Yrs. Director **Usual Residence of Decedent** 10a State 10b County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland More 238-1 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 212 "natural", or items 23s Funeral 12. Wea Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be illed Department of Health and Mental Hygh Important: If them 27 is marked other 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (Firşt, Middle, Maidan Sumama) Be Den Iam 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code), 21(33 19a. Informant's Name/Relationship (Type, Print) Kandallstown, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Son 4 □ Donation 5 □ Other (Specify) TORR 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Horr orth Aug. 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Alzheimer's Dementia /Medical Immediata Cause (Final disease or condition resulting in death) tenyears Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 280 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 No or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4☐ Nursing Homa 5 Residence 8 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral is 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, etreet, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ristin MClark, MO 2/10/00 00053966 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Kristin in Clark win Ave Ste 100 Baltimore mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar



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item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Madical Examinar mans on notified at

should be filed within 7, and Mental Hygiene.

2 should be fand Mental H

Pages 1 and 2 sh ment of Health and ent: If item 27 is m

permit. Page Department (Important: If any injury or

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Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury

that initiated events resulting In death) Last

Pulmonney

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6 Could not be

25. Was casa referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

Hospitai: 1 Impatient 28a. Date of Injury (Month, Day Year) 5 Pending invastigation

2 ER/Outpatient 3 DOA 28b. Time of

28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 - Homicide

3 Sulcide

Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

29d. Data signed (Month, Day, Year)

Lee alisin onyder, Resident Physician

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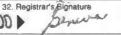
30. Name and eddress of person who complated cause of death (item 23a) (Type, Print)

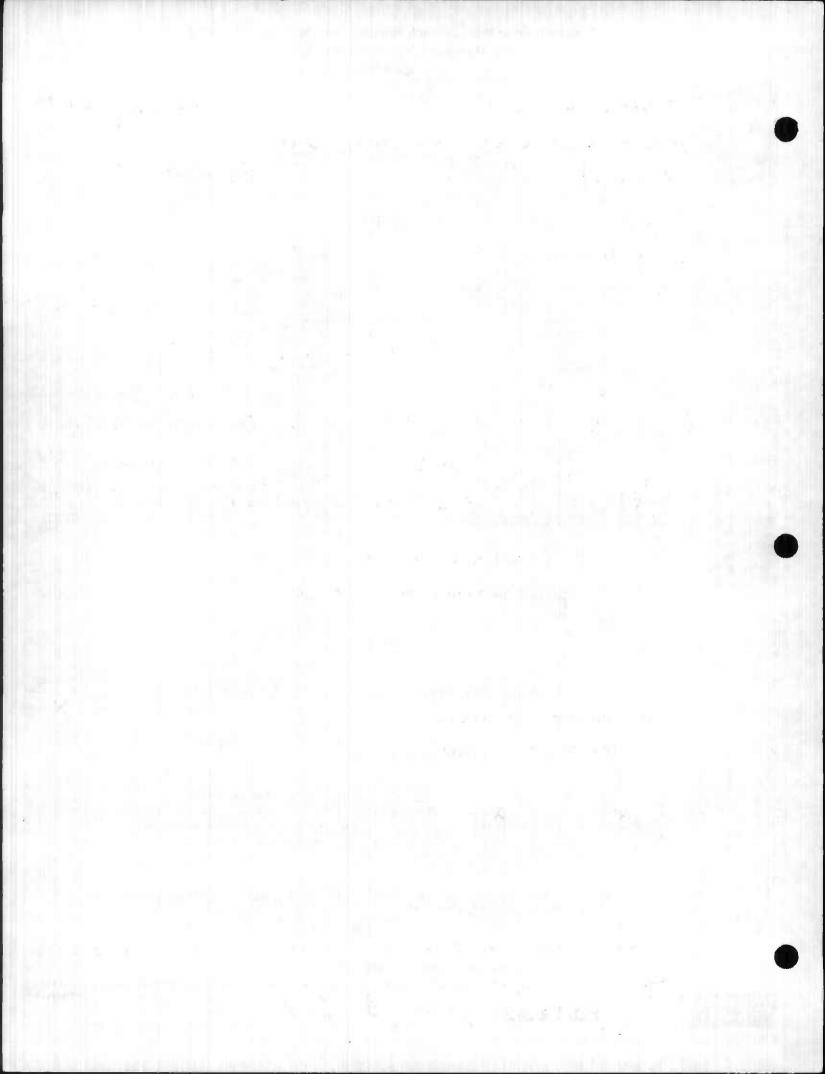
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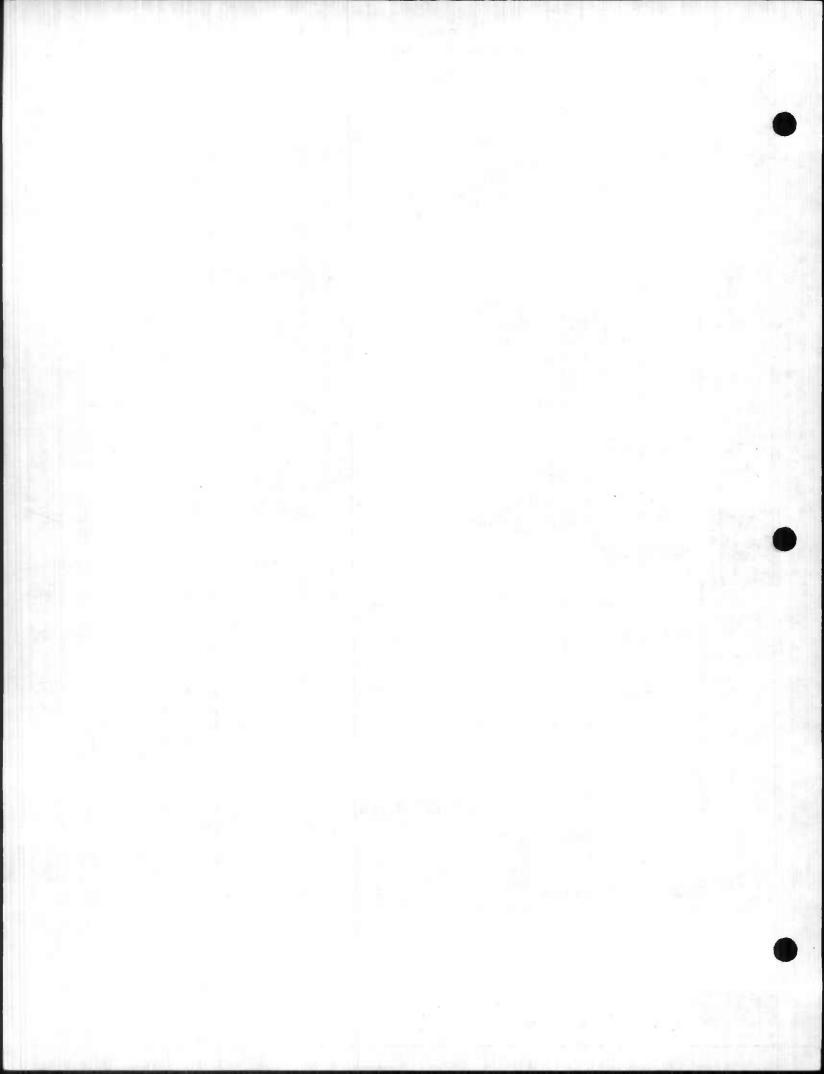


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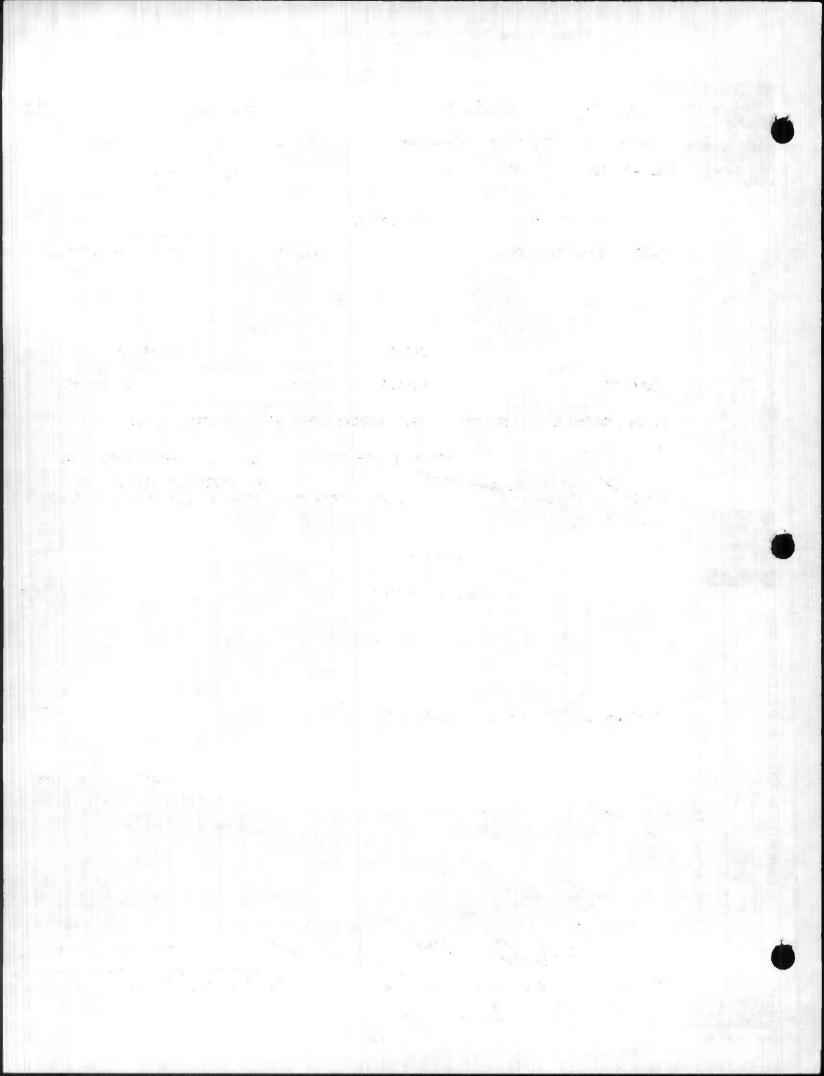
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32. Registrar's Signatura

D. Books



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedant's Name (First, Middle, Last) 1/38 Month **Physician** MILLER 10 >000 4c. County of Death AISA TERRUSTY /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) Examiner NONTHWEST HOSPITAL CENTER RANDAII STOWN BALTI MORE If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Deys 1□M 2K F Months 215-49-8116 Yrs. 91 RUSSTA Director Usual Rasidence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XNo BALTIMORE BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 211208 U.S.A. REFUGEE STATUS 7920 SCOTTS LEVEL ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. than "natural", or items the Medical Examiner m 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) CLERK ACCOUNTING 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middla, Last) Be . Pages 1 and 2 should be ment of Health and Ments tant: If Itam 27 is marked SOLOMON MILLER **OLGA** DAVIDOVNA marked Lo 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) LILIYA SHVARTSMAN / NIECE 6970 MARSUE DRIVE #1-B, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Ramoval from State HAR SINAI CEMETERY 2/11/00 OWINGS MILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee (hur 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onset and Death **Physician** FOU DAYS Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or es e consequence of): Examiner DNEUMON, A Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last Due to (or es e consequence of): physician s the buria Box 68760, certificate be Physician/Medical Due to (or as a consequence of): as 980 Part fl. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part it. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRICATION Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 ☐ MG 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 1 Neturel 5 ☐ Pendina after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the bests of axaminetion end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) 29d. Data signed (Month. Dav. Year) 29c. Licansa number 29b. Signatura and title of continue and 30. Name and address of person who completed cause of death (item 23e) (Type, Print) QULHNOS Co. NANTO Digital rar's Signature 31. Data filed (FEB 1 4 2000 Registrar B. Sparks **DHMH 16 Rev 6/95**

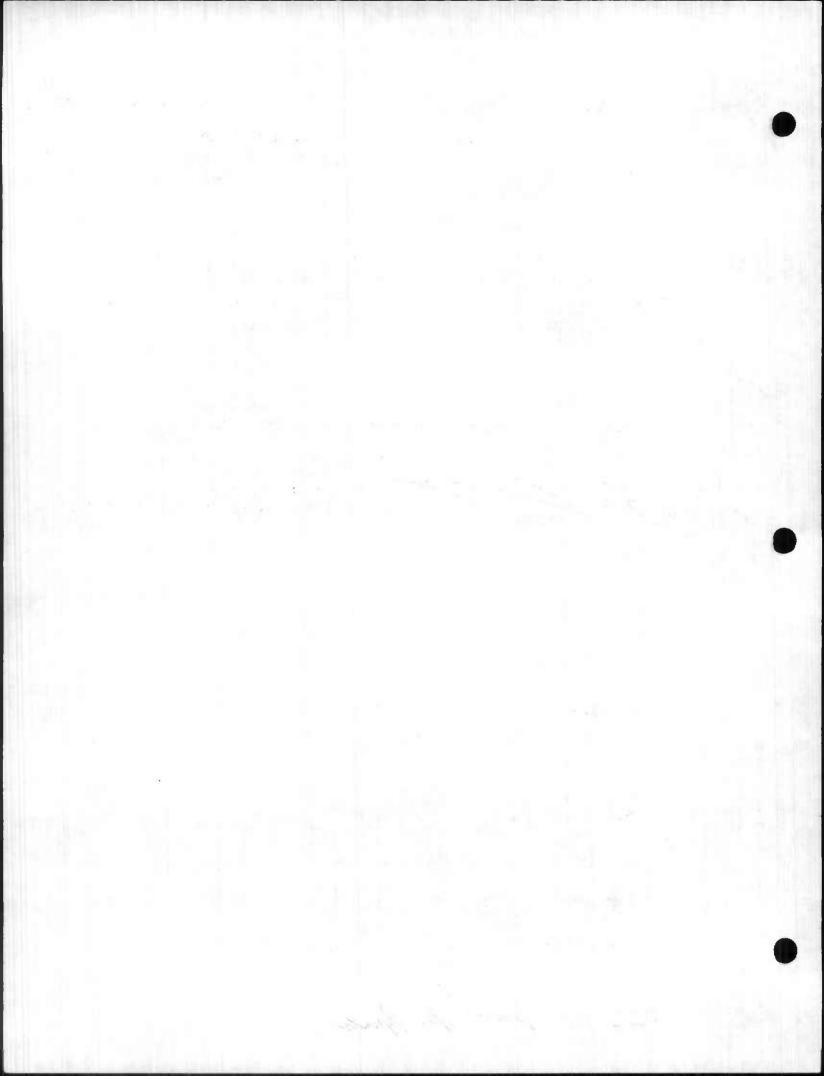


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State of Maryland / Department of Health and Mental Hygiene 00 01, 363

| | | | | | | Ce | rtificate | e of | Death | | | Reg. No. | 00 | 04 | 000 |
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| | Di atalan | 1. Decedent's Nama | (First, Middle, La | st) | | | | | -112 | - 1 | 2. Data of D Month | eath Day | Year | 3. Ti | ima of Death |
| | Physician /Medical | EVELYN V | IRGINIA | MCKINNE | EY | | | | | | FEBRUA | RY 11 | ,2000 | 11 | :00 A.M |
| | Examiner | 4a Facility Nama (If r | | | | | | | | | ocation of Dea | | county of Dea | | E |
| _ | | MARINER 5. Social Security Nur | | | CARE 7. Aga (In yrs. I | la má faileith eile a s | If Under | 1 Voor | | | RE CITY 8. Data of B | | N/A | | |
| L | Funeral Director | 212-03-99 Usual Rasidance of D | 940 | □M 280F | 85 | Yrs. | Months | Days | | Min. | 6/22/] | ay, Year) | C | w YO | RK |
| | ehow ehow | | 10b. County | | 10c. City | , Town or Lo | cation | | | | | | | 10d. Ins | ide City Limits |
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| | death with the Meryland rms 23a or 28s-f show r must be notified at neral Director | 10e. Street and Numb | per | | | | 10f. Zip | Code | | | = | 10g. Citize | on of What Co | ountry? | |
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| 020 | or he mine | | | 12. Was Deced Armed Ford 1 Tas 2 If Yes, Give Yaar or Da | 2√∑ No | | If Yas, spec | ify Cub | Hispanic Or van, Mexica Specify: | n, Puerto | ecify Yes or N Rican, etc.) | | I. Race - Ame Bleck, White Specify: | te, etc. | an, |
| 5-0020 | "natural". | 1 | 5. Decedent's Ed | ducation | | 16a. Dece | dent's Usua | I Occu | pation | | | 16b. Kind | of Business | HITE /Industry | |
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| yla | and Mental Hygis marked other surratic event, To Be Co | HARVEY BO | DND | | | | | | BLA | NCHE | UNAVA | AILABL | E | | |
| Maryland | C/ 8 | 19a. Informant's Nam | ne/Relationship (| Type, Print) | | 19b. Mailie | ng Addrass | (Stree | t and Numb | er or Rui | al Routa Num | ber, City or | Town, Stata, | Zip Code) | |
| | ges 1 and t of Health if item 27 or other tr | DOLLY STO | | DAUGH | | 3702 | | | N AVE | NUE | BALTIN | | | 206 | |
| Ore | 00 | 20a. Mathod of Dispo | | Ramoval from S | tata | matary, cre | metory or of | har pla | | i | Data | | ation - City or | | |
| Baltimore, | | 4 Donation 5 | Othar (Specif | y) | ME | TRO CR | | | | | /12/200 | O CA | TONSVI | LLE, | MD |
| Bal | Department Department Important: h any injury o | 21. Signatura of Funa | aral Sarvice Licer | 1600 | | | | | ASS OF FACILITY | | L HOME | D A | | | |
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| 1 | | 23) Part Enter the | disaase, or com failure. List only | plications that∕ca ona causa on aa | used tha death ch lina. | . Do not en | er the mode | of dy | ng, such es | cardiac | or respiratory | errest, | | Interv | el Between and Deeth |
| | Physician /Medical | Immediata Cause (Fi | inal | 11 | REISK | 2011 | 151 | -// | 100 | | 1.00 | -101 | 71,- | 1 | 40 |
| | Examiner | disaasa or condition rasulting in daath) | | a. CE/ | - | | | | 411 | | The | 100 | 707 | | 111 |
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| 68760, | ca bu | I that initiated evants | | c | Dua to (or | as a conseq | uence of): | | | | | | | | |
| | ng physicians as the bu | rasulting In death) La | st | | | | | | | | | | | | |
| Box | | | | d | | | | | | | | | | 1 | |
| | | Part II. Other algorifica | ant conditions c | ontributing to dea | th but not rasu | Ilting in the u | nderlying ca | ause gi | ven in Part | l. | 23b. Dic | I tobacco u | se contribut | e to the c | suse of death? |
| P.0 | law requires that the dot as been signed by the 2 should be detached npleted by Physic | COTTE | PAPARY | ARI FIB | TERIL | 75C | LER | 0- | 5/5 | | 10 | Yes 25 | KNo 3 P | robably | 4 Unknown |
| | be be be | 1 0 | - | | 0.1 | | 7.0.0 | 1 | | | | | | | |
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| lec | has b | | | | | | | | | | | | | of death? | ii oi oauso |
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| of | this cal direction. | 1 Yas 2 N | 0 | | patiant 2 1 | • | | A | - | ursing Ho | oma 5 🗆 Res | | | acify) | |
| E | Br feet CO | 27. Manner of Death | 5 Pending | 28a. Data of (Month | Injury , Day Year) | 28b. Tima o Injury | | Bc. Inju | | | 28d. Describe | how injury | occurred | | |
| Sign | Attending or death. ector: After by the fune | 2 ☐ Accident 3 ☐ Suicida | invastigation | | Alaban AAban | | M | | Yas 2 | INO | 29f Location | (Ctonat and | Alumbar or F | Aurel Pour | a Alumbac |
| Division | tal or Attending P rs after death. el Director: After t led in by the funera Certification: | 4 Homlcide | determined | 26a. Placa (| of Injury - At ho g, atc. (Specify | ma, tarm, sti | eet, factory | , office | | | 28f. Location City or To | own, Stata) | Number or r | Urair Pioure | t Number, |
| _ | To the Hospital or Attendition within 24 hours after death. To the Funerel Director: A completely filled in by the filled and by the filled of | 29e. Certifier (Check only one) | Cardlying Fin | yeldan: To the b | sis of axamineti | vledge, deeth | n occurred e vastigation, | et the ti | ime, date ar opinion, dec | nd place, eth occur | and due to the red at the time | cause(s) a | and manner a place, and du | s stated. e to the ca | iuse(s) |
| | Nethin Somple | 29b. Signature and tit | inter Entities | | - | - | 29c | . Licen | se number | | , | 29d. Data | signed (Mon | th, Day, Y | ear) |
| | ->-0 | * 4 | kell | en | IN | 1 | | DO | 183 | 44 | ' | 2 | /11/ | 00 | |
| | 1 | 30. Name and addras | s of person who | completed cause | of death (Item | 23e) (Type | Print) | | | | | | | | |
| | H | | 714 Hari | | | imore | | | | | | | | | |
| | State | 31. Data flled (Month, | | | gistrar's Signat | | | | | | | | | | |
| | Registrar | FEB 1 | 4 2000 | Sen | va , | 9. | pour | 10 | | | | | | | |
| 1 | MH 16 Day 6/05 | | 1000 | - | | 1 | - | - | | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** NICHOLAS BRUCE MARTIN 2000 FEB 6:02 PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 6. Date of Birth | Months | Davs | Hours | Min. | Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthplace (Steta or Foreign Country) **Funeral** 1₽M 2□ F Months Days 59 **Director** 225-52-6166 D.C. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylei Department of Heelith and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 23s-4 show any injury or other traumatic event, fra Medical Example must be notified a once. 1 ☐ Yas 2 No Directo VA Loudoun Sterling 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 21152 Twinridge Square 20164 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Biack, Whita, atc. 11. Marital Status 1 Yas 2 No If Yes, Give Yaer or Dates: 1 ☐ Never Married 2 1 Married Saltimore, Maryland 21215-0020 1 Yes 2 No þ Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Specialist N.I.H. 17. Father's Name (First, Middle, Last) 16. Mothar's Name (First, Middle, Melden Sumema) Be Nicholas Bruce Martin Margaret H. Carroll 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Ruby E. Martin - wife 21152 Twinridge Square Sterling, VA 20164 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2-12-00 4 ☐ Donation 5 ☐ Other (Specify) Chestnut Grove Cemetery Herndon, VA 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Green Funeral Home, Inc. 1.121 721 Elden St., Herndon, 23a. Part1. Enter the disease, or complications that countries the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physiclan /Medical Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CANCER Examiner Due to (or as a consequence of). Examiner that the death certificate be executed physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequance of): 100 950 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 1 ☐ Yes 2 ☐ No certificata Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica 25. Was case referred to medical axaminar? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2√2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) In by 4 Homicide filled 24 hours 29a. Cartifle 🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of partifier 29c. License number 29d. Data signed (Month, Day, Year) 16000 (MS) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

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DHMH 16 Rev 6/95

State

Registrar

DAVID E. ALLEN, LT, MC, USN

FEB 1 4 2000

32. Registrar'a Signature

Lener

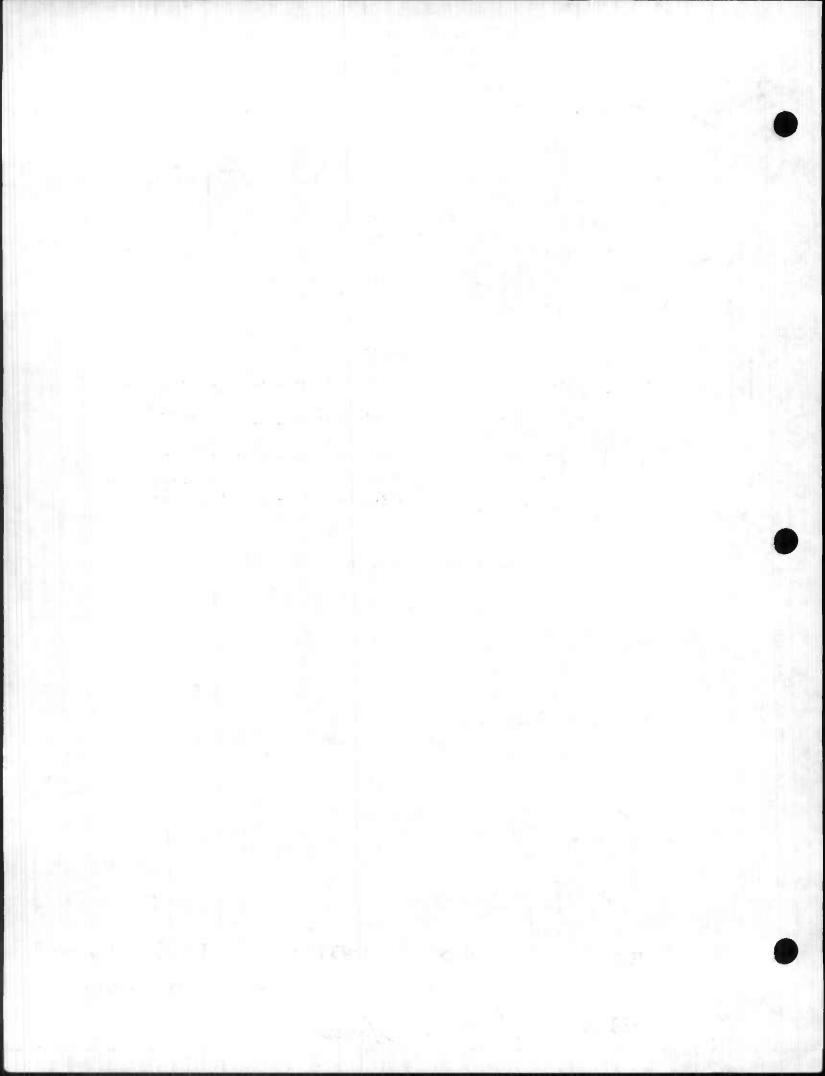
31. Date filed (Month, Dey, Yeer)

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|----------------------------|---|---|--|-----------------|---|--|---|---------------------------------------|--|--|---------------------|
| | Physician /Medical | 1. Decedent's Name (First, Middle Caroline W. | | | | | | 2. Date of De Month | ath Day | Year 2 4 | of Death |
| | Examiner | 4a Facility Neme (If not institution NORTH A | FRUNDEL | - H | DSPITA | Under 1 Year | 4b. City, Town, or L GIEN B If Under 24 Hrs. | URNIE | AA | COUNTY | to as Familia |
| | Funeral Director | 5. Social Security Number 218-07-3186 Usual Residence of Decedent | 1□ M 2ÅF | 82 | | onths Days | Hours Min. | 8. Date of Bir (Month, Da March | 25,1917 | 9. Birthplace (Star Country) MD | e or Foreign |
| il With the Maryland | be notified at Director | MD Anne 10e. Street and Number | Arundel | | en Burn | Î C Of. Zip Code | 1061 | | 10g. Citizen of V | 1 D Y | City Limits |
| Hall | raf, or farms 23u Examiner must d by Funeral | 390 Fleagle Rd 11. Merital Status 1 Never Married 2 Mai 3 Widowed 4 Divorces | 12. Was Decedent Armed Forces 1 Yes 2 | ? KNo | | | dispanic Origin? (Sj an, Mexican, Puerto Specify: | pecify Yas or No o Rican, etc.) | | e - American Indian ck, White, etc. | , |
| 0 COH, d 21215-0020 | Hygiene, ther than "naturn int, the Medical." Completed | 15. Deceder (Specify only higher Elementery/Secondary (0-12) 12 | t's Education st grade completed) College (1-4or | 5+) | 16a. Decedent'. (Give kind life. DO N | of work done IOT use retired | pation during most of world) 18. Mother's Nem | | 0wn | Home | |
| arylan should be | amarked of umarked of umaric ever To Be | William H. Sch | elhause ship (Type, Print) | | | | Wilhemi and Number or Ru | na Jose | phina Ke er, City or Town, | hn State, Zip Code) | |
| Mayor 1 and 2 | ant of Health a t: If Item 27 is y or other tra | Raymond Magnes 20a. Method of Disposition 1 N Burial 2 Cremation 4 Donation 5 Other (3 | 3 □ Removal from State | C | lace of Disposition emetery, cremator | n (Name of ry or other pla | 1 | Date | 20c. Location - | MD 21093 City or Town, State burg, MD | |
| Baltimor | Department important any injur ance | 21. Signature of Funeral Service | | ~ | 22. Na | me and Addre | | 11824 | | stown Rd | 36 |
| 8760, ate be executed | attending physician and leading physician and leading | 23a. Aart . Enter the disease, o shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | only one cause on each | Due to (or | | Llav for control of the control of t | Acudei Failure | | irrest, | Approxil Interval Onset a | Batween nd Death |
| P.O. | ate has been signed by the attending p. page 2 should be detached for use as Completed by Physician/Mer | Part II. Other algnificant conditi | arteny T | DISEC | ulting in the under | lying cause gh | ven in Part f. | | | ntributa to the cau | |
| ecords aw requires | 2 should b | ATRIAL FI | brillation | | | 194 | | 24a. Was | an autopsy ormed? | 24b. Were autop available pr completion of death? | ior to |
| Vital Relicion: The la | certificate has rector, page 2 | AZOTEMIA 25. Was case referred to medical examiner? | Hospital: | epsi | S | Ot! | 26. Place of Dea | ith (Check only | | 1 🗆 Yas | 2 No |
| Division of Vital Records, | within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com | 1 Yes 2 No 27. Menner of Death 1 Netural 5 Pendi | 28a. Dete of Ing (Month, D | ury ey Year) | 28b. Time of Injury | 28c. Inju Wo | ry at rkr? Yes 2 No | 28d. Describe | idence 8 Oth how injury occur (Street and Numburn, State) | | Vum <i>ber</i> , |
| Di Hospital or | Funeral Dir Funeral Dir stely filled in dical Ceri | 29a. Certifier 1 Certifyi | ng Phyalcian: To the besis | t of my know | wiedge, death occ | curred at the ti | ma, dete end place | , and due to the | cause(s) end ma | | se(s) |
| Tothe | within To the comple | 29b. Signature and title of certific | | ms. | • | 29c. Licens | se number | | 29d. Date signed (Month, Day, Year) | | |
| | State | 30. Name and address of person Oyo K Oye 31. Date filed (Month, Day, Year | injo- 301 | death (Item | ital 9 | rul | Colen B | urnà | · my. | 21061 | |
| | Registrar | EED 1 / | 2000 | | 6 | | | | | | |

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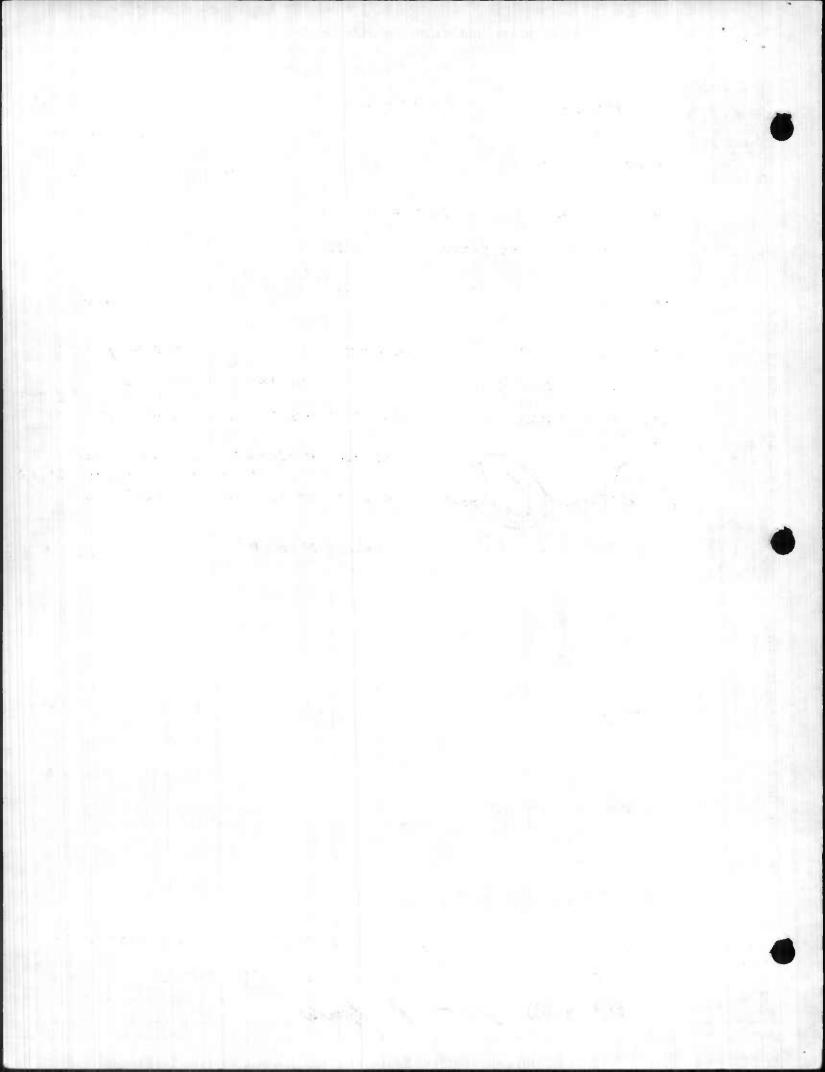
DHMH 16 Rev 6/95



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| | | | | Ce | rtificate of | Death | | Reg. No. | | |
|------------|--|--|---|-------------------------------------|---|---------------------------------|---|--|--------------------------------------|--|
| | Physician /Medical | 1. Decedent's Neme (First, Middle ALBE | RT RT | PATTI | ERSO/ | J | 2. Dete of Month | Dev | Yeer 2000 | 3. Tims of Death |
| | Examiner | 4e Facility Name (If not institution, NO LTH WEST | give street end number) | TAL | | MAN | m, or Location of D. DALLS To | an BA | | MORE |
| | Funeral Director | 219-22-4072 | | (In yrs. last birthday, 19 Yrs. | Months Days | | Min. (Month, | Birth Dey, Yeer) 4-21 | 9. Birthp Cour | olece (Stete or Foreign etry) MD |
| | and show of start show of sector | Usual Residence of Decedent 10a. State 10b. County MD NA | | 10c. City, Town or L Baltime | | | | | 1 | 0d. inside City Limits Xd Yas 2 □ No |
| | iter death with the Marriters 23a or 23a-f since the most of the following the most of the Funeral Director | 10e. Street and Number 3942 Southerr | Cross Dri | ve | 10f. Zip Code 2120 | 7 | | 10g. Citizen of USI | | ntry? |
| 21215-0020 | by by | 11. Marital Status 1 Never Merried 2 Merrie 303Widowed 4 Divorced | 12. Was Decadent E Armed Forcas? 1 Yes 2000 If Yes, Give Yeer or Detes: | | Wes Decedent of if Yes, specify Cu 1□ Yes 22 32 No. | ben, Mexican, | in? (Specify Yes or Puerto Rican, atc.) | | ce - Amaric ock, White, fy: B] | |
| 15-0 | ed within 72 ho ygiene. or then "natural, ft, ff Medical Completed | 15. Decedent' (Specify only highest | | 16e. Dece (Give | dent's Usuei Occi kind of work don DO NOT usa retir | upation e during most | of working | 16b. Kind of E | Businass/In | dustry |
| 121 | within than the than the than the the the the the the the the the the | Elementery/Secondery (0-12) 3rd. Grade | College (1-4or 54 | +) | oorer | 90) | | vario | ous t | rades |
| | should be filed within ad Mental Hygiene. merked other than imatic event, the M | 17. Father's Nema (First, Middle, L | | | 00202 | 18. Mother | r's Neme (First, Mid | | | |
| /lan | 2 should be and Mental is marked o burnatic eve | Daniel | Patterson | | | Mab | le | Aquil: | la | 01005 |
| , Maryland | 2 2 2 2 | 19a. Informant's Name/Raietionsh Harrison A. I | | 19b. Meil 39 | ing Address <i>(Stree</i> 42 Sout | hern | r or Aural Aoute Nu Cross D | mber, City or Town | , Stete, Zip ltimo | ore, MD. |
| altimore, | ages ant of it: If it y or o | 20a. Method of Disposition Buriai 2 Cremation Donation 5 Other (Sp | | | metory or other pi | | ens 02- | 20c. Location | | dalk, MD |
| Balt | pemit. Pa Departmen Important: any Injury pacs. | 21. Signature of Funeral Service L | icense | lana and a second | 2. Neme end Add | | Baltin H 1101 | | | and 21202 enue |
| | Dh. al-la- | shock, or heert failure. List of | contilications that contied in | | | | | | | Approximate intervel Between Onset and Deeth |
| | Physician /Medical Examiner | immediate Ceuse (Finel diseese or condition resulting in deeth) | · MR | | PNEU | MON | MA | | | 12 DAYS |
| | iner ar | | - b | Due to (<i>o</i> r es a conse | quence of): | | | | | |
| 68760, | The law requires that the death certificete be executed at has been signed by the attanding physician end page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last | c | Due to (or es e conse | | | | | 1 | |
| Box 68 | eath certifice attanding phase as the control of th | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | d | | | | | | | |
| P.O. B | as that the death cert igned by the attandin be detached for use by Physician/M | Pert ii. Other eignificant condition | s contributing to deeth but | t not resulting in the | underlying cause (| given In Pert i. | | Old tobacco use c | | o the cause of death? |
| | as that igned to be det | DMI | | | | | | | | |
| Records, | The law require sate has been si page 2 should Completed | | | | | | | Ves an eutopsy erformed? | ev | lere autopsy findings vailable prior to empletion of ceuse death? |
| R | yalclan: The law s certificate has director, page 2 To Be Comp | | | | | | 1 | □Yes 2□X6 | 1 | Yes ZORo |
| Vital | certificate rector, pag | 25. Wes cese referred to medical axaminar? | Managaria - | | | | of Deeth (Check of | nly one) | | |
| of | | 1 Yes 2 No | Hospital: Inpatier | | nt 3LI DOA | | rsing Home 5 F | tesidence 6 0 | | fy) |
| O | ding h. After funer | 1 Pending 2 Accident Investig | | Year) Zob. Time (| W | ork? ☐Yes 2☐1 | | ibe now injuly book | 11100 | |
| Division | tel or Attending P is efter death. al Director: After t led in by the funera Certification: | 3 Suicide 6 Could n 4 Homicide determine | ot be | ry - At home, ferm, st (Specify) | reet, factory, offic | 9 | | on (Street and Num Town, Stete) | nber or Run | al Route Number, |
| Ī | To the Hospital or Attending Ph within 24 hours effar death. To the Funeral Director: Affer th completely filled in by the funeral Medical Certification: | 29e. Certifier Certifying (Check only one) | Physictan: To the best of xaminer: On the basis of end menner stell | exemination and/or in | h occurred et the evestigetion, in my | time, date end oplnion, deat | d plece, end due to h occurred at the ti | the ceuse(s) end n ne, dete end plece | nenner as a , and due t | stated. to the cause(s) |
| | within To the Comp | 29b. Signeture end title of certifier | Nan | Ly | 29c. Lica | 373 | 13 | 29d. Data sign | | Dey, Year) 8, 2000 |
| | M | 30. Name end address of person v | ho completed cause of de | eth (item 23e) (Type | Print) JA | LTO. | MD 2 | 1133 | | |
| | State Registrar | 31. Deta filed (Month, Day, Year) FEB 1 4 | | r's Signeture | Span | Ka | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 04367 Certificate of Death 2 Data of Death 3. Tima of Death 1. Decedant's Neme (First, Middla, Last) February 10, 2000 4c. County of Depth 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) H Under 1 Year H Under 2011 General aryland 5. Social Sacurity Number (In yrs. last birthday) 6. Sex 9! Deys 1□M 2XF 420-46-2032 Usual Rasidence of Dacedant Yrs. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland mor 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda Ul 12. Was Dacedant Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, etc. Wes Decedant of Hispanic Origin? (Specity Yas or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Maritel Status 1 Never Married 2 ☐ Married ☐ Yes 2 No f Yas, Giva 1 □ Yas 2 No Specify: 3 ☐ Widowad 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work dona during lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 18. Mothar's Nema man Stata, Zjp Coda) 19a. Informant's Name/Retationship (Type, Print) SIS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or d. 2 SSIR 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition Day 20c. Location -City or Town, Stata 1 Burial 2 Cramation 3 Ramovel from Stete 4 □ Donation 5 □ Othar (Specify) 22. Nama and Address of Fecility L. Russ W. North Joseph ra Ave Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximata Interval Between Onsat and Death Immediate Ceuse (Finel disaese or condition resulting In deeth) Due to ter es e consequence of) Due to (or as a consequence of): Dua to (or as a consaquanca of) 23b. Did tobacco usa contribute to the cause of geath? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 18 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona)

Physician /Medical Examiner

ettending physician and for use as the buriel-transit

signed by the e

as been sign

i certificate has linector, page 2:

After this

To the Funeral Director International Property Communication of the Comm

ector: A

3

death.

The lew requires that the death certificate be executed

or Attending Physician:

To the Hospitai

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

p

Completed

Be

P

Certification:

edicai

1 Yas

29a. Certifian

(Check only

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

þ

Completed

To Be

Director

important: if Nem 27 is marked other than "natural", or Nems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at another.

Peges 1 and 2 should be filed within 72 hours efter deeth

Department of Health end Mental Hygiene.

Floubse Petite

with the Meryland

Sequantially tist conditions, if any, laeding to immadiata causa. Entar Undarfying Ceuse (Disease or Injury that initiated avents rasulting in death) Last

Hospitel: 20 No 1 Inpatiant 2 ER/Outpatient 28a. Date of tnjury (Month, Dey Year)

Othar: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 3□ DOA

27. Manuar of Death 1 D Neturet 5 Pending investigation 2 Accident 6 Could not be detarmined 3 Suicida 4 Homicide

FEB 1

28c. Injury at Work? 28d. Describe how Injury occurred 2 □ No 1 Yas

Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 1 Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner es stated.

one) 29b. Signeture end title of certifier

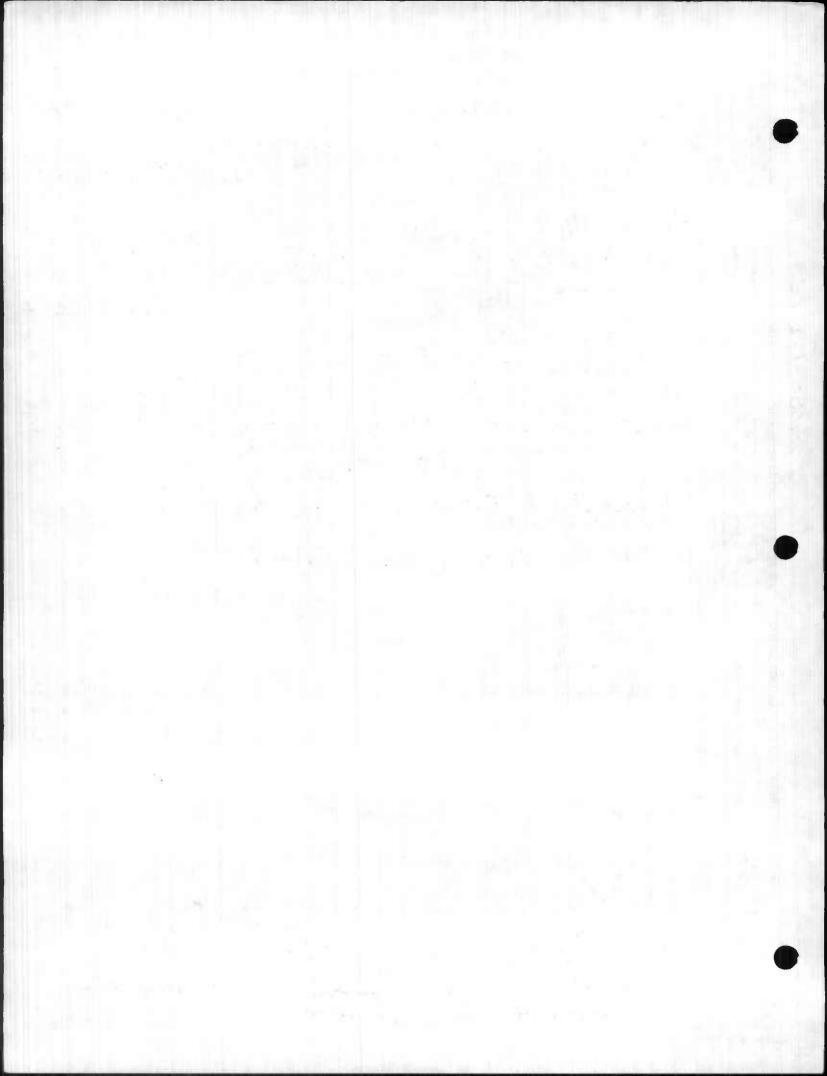
2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Nama and address of person who completed causa of deeth (Item 23e) (Type, Print)

29d. Data signed (Month, Day, Year) 29c. Licanse number

reneral 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

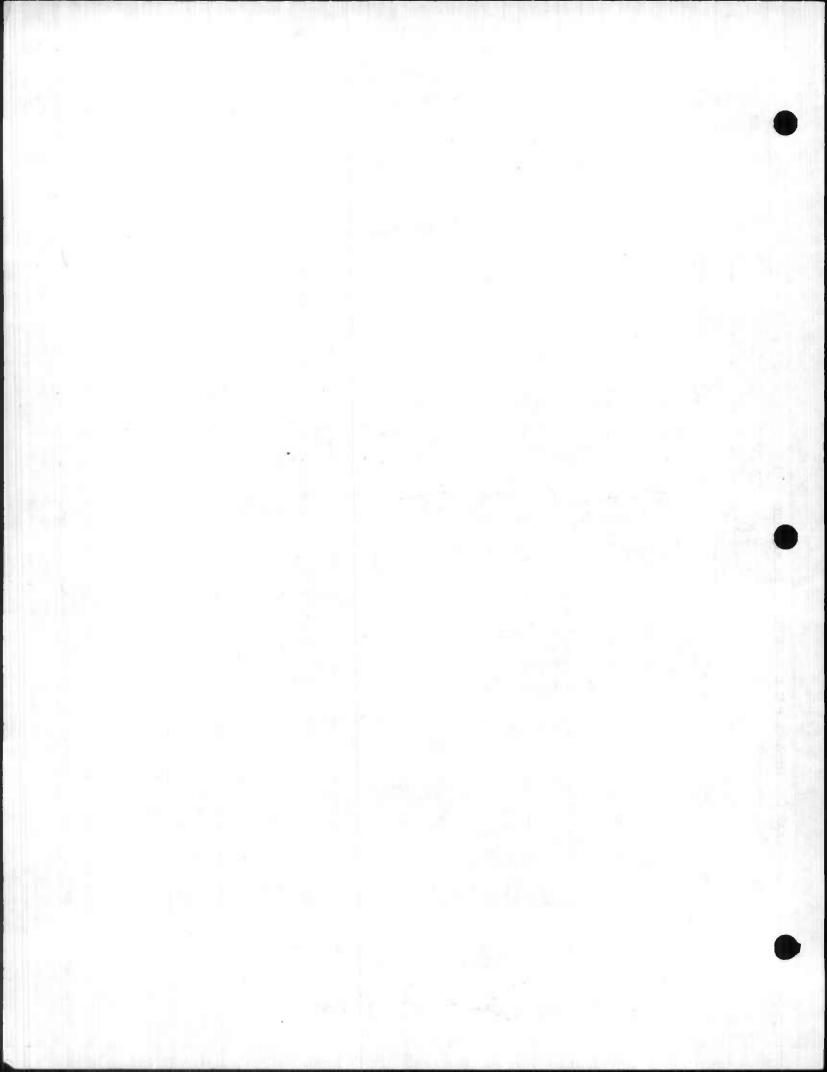
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate of | Death | Re | g. No. U | 04368 |
|---|--|---|--|--|--|-------------------------------------|---|
| | 1. Decedent's Name (First, Middle, Last) | . 0 | | | 2. Dete of Death Month | | 3. Time of Death |
| Physician /Medical | Sharon Deni | se Parke | | | February | 9 2 | oce 6:06 AM |
| Examiner | 4a Facility Name (If not institution, give st | | | 4b. City, Town, or I | | 4c. County of | |
| 91 | Harbor Hosp | ital Cent | er | Balti | more | N | A |
| Funeral Director | 5. Social Security Number 6. Sex 217-74-5157 | 7. Age (fn yrs. la: | st birthday) If Under 1 Yea Months Days | | 8. Date of Birth (Month, Day, 09-02- | Year) -58 |). Birthplace (State or Foreign Country) MD |
| 2 | Usuat Residence of Decedent | 140.00 | *** | | | | |
| death with the Maryland ms 23a or 28=1 show rms the modified at meral Director | 10s. State 10b. County | 10c. City, | Town or Location | | | | 10d. Inside City Limits 1 □ Yes 2 □ No |
| with the Man | MD NA | Ba | altimore | | | | |
| Die ville | 10e. Street and Number | | 10f. Zip Code | | 10 | g. Citizen of Wh | at Country? |
| a 23 | 2833 Seamon Ave | | 2122 | | | USA | American to desi |
| O he di | X Never Married 2 Married 3 □ Widowed 4 □ Divorced | 2. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 13. Was Decedent of It Yes, specify Cul | | Rican, etc.) | | American Indian, Whita, etc. Black |
| Maryland 21215-002 d 2 should be filed within 72 hours th and Mental Hygiene. T is marked other than "natural", traumatic avent, the Medical Ex- | 15. Decedent's Educi (Specify only highest grade | ation | 16a. Decedent's Usual Occu | upation | kina 1 | 6b. Kind of Busin | ness/Industry |
| within within than the | Elementary/Secondary (0-12) | College (1-4or 5+) | (Give kind of work done life. DO NOT use retin | | | | |
| d 212 filed with Hygiene. ont, the | GED | NA | License Pra | | | | st N.H. |
| De de de de de de de de de de de de de de | 17. Father's Name (First, Middle, Last) | | | | ne (First, Middle, M | aiden Sumame) | |
| Maryland d 2 should be flie th and Mentel Hy 7 is marked oth traumatic avent To Be (| Joseph Parke | er | | Mary | E. C | rest | |
| 2 sh | 19a. Intormant's Name/Reletionship (Type | e, Print) | 19b. Mailing Address (Street | et and Number or Ru | ral Route Number, | City or Town, St | ate, Zip Code) 21225 |
| other tr | Mary E. Parke | | 2833 Seamor | n Avenue | Baltim | ore Ma | ryland |
| Baltimore, permit. Pages 1 an permit. Pages 1 an important: if Item 2 any Injury or other once. | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re | mount tram State Cen | ce of Disposition (Name of netery, crematory or other pl | lace) | Date 2 | 0c. Location - Ci | ty or Town, State |
| Pages nent of I | 4 Donation 5 Other (Specify) | Gre | enmount Cer | | | | ltimore,MD |
| Baltim pemit. Pag Department important: I any Injury o | 21. Signature of Funeral Service Licensy | 21 | 22. Name and Addi | ress of Facility B | altimore | e, Mary | yland 21202 |
| 0 88 5 8 | Harris 1 | Hear & | WM . C . Ma | arch FH | 1101 F | North | Arronno |
| | 23a. Part1. Enter the disease, of complice shock, or heart tailure. List only one | ations that caused the death | | | | | Approximete |
| Physician | snock, or neart tailure. List only one | cause on each line. | | | | | Intervat Between Onset and Death |
| / /Medical | Immediate Cause (Final | Bilatera | 1 Dogge | - 010 | | | Man Wast |
| Examiner | disease or condition resulting in death) | | es a consequence of): | orna | | | one week |
| ةِ الساساء | | Metastate | i Branch | Carcin | 16 110 | | 9 math |
| 68760, trificate be associted to physician and as the burial-transit | Sequentially list conditions | 1 | as a consequence of): | Carcii | CINIO | | 1 Proninc |
| Ex Paris | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. | | Constitution of the consti | | | | |
| ficate be any physician as the burial edical E | triat initiated events | Due to (or a | is a consequence of): | | | | |
| Hillon Hillon | resulting in death) Last | | | | | | |
| Noser russ | d. | | | | | | 1 |
| dest dest dest dest dest dest | Part II. Other significant conditions contr | ributing to death but not result | ing in the underlying cause g | iven in Part I. | 23b. Did tob | acco usa contr | ibuts to the cause of death? |
| S, P.O. BOX set that the death cer igned by the attendin be detached for use by Physician/N | | | | | 1□ Ya | a 2□ No 3 | Probably 4 Unknown |
| require hould | | | | | 24a. Was en periorm | | 24b. Were autopsy tindings available prior to completion of cause |
| Hest Pess | | | | | | V | of death? |
| S stage | | | | | 1 ☑ Yes | 2 DNO | 1 ☐ Yes 2 ☐ No |
| clen: clen: ector | 25. Was case referred to medicat examiner? | the L | | | th (Check only one |) | |
| hysic his o | TU YBS ZUNO | | HVOutpatient 3LI DOA | | ome 5 Resider | | |
| The P | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 8b. Time of 28c. Injury | | 28d. Describe how | w injury occurred | |
| DIVISION Of VITAI or Attending Physicien: T after death. Director: Attential conflicat in by the funeral director, p entification: To Be C | 2 Accident investigation | | | Yes 2 No | | | |
| DIVISION C tall or Attending P is after death. at Director: After to led in by the funeral Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At hom building, etc. (Specify) | e, farm, street, factory, office | Э | 28f. Location (Str. City or Town, | | or Rural Route Number, |
| | | | | 1-1-1-1 | | | |
| ne Hospi n 24 hound ne Funer pletely fill | (Uneck only 2 Medical Examine | clan: To the best of my knowler: On the basis of examination | edge, death occurred at the to and/or investigation, in my | time, date and place opinion, deeth occu | , and due to the car rred at the time, da | usa(s) and mann te end place, an | er as stated. d due to the cause(s) |
| DIVISION Of VITAI REC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s Medical Certification: To Be Compil | one) | and manner stated. | | | | | |
| 4168 | 29b. Signature and title of certifier | MA | 1 | nse number | | | Month, Day, Year) |
| . \ / \ | April Halano | - Calab | | 2291 | re | bruary | 9-2000 |
| 1111 | 30. Name and address of person who com | npleted cause of death (Item 2 M. 300 i Sc 30 Rehistrar's Signature | 3a) (Type, Print) | - 04 | 0 11. | | 1001100 |
| 110 | Harry G. Salar | na.300150 | run Hanove | r Street | Ballin | nore 14 | U alado |
| State | 31. Date tiled (Month, Day, Year) FFR 1 4 2000 | 32. Registrar's Signatur | " & Sport | 2 | | | |

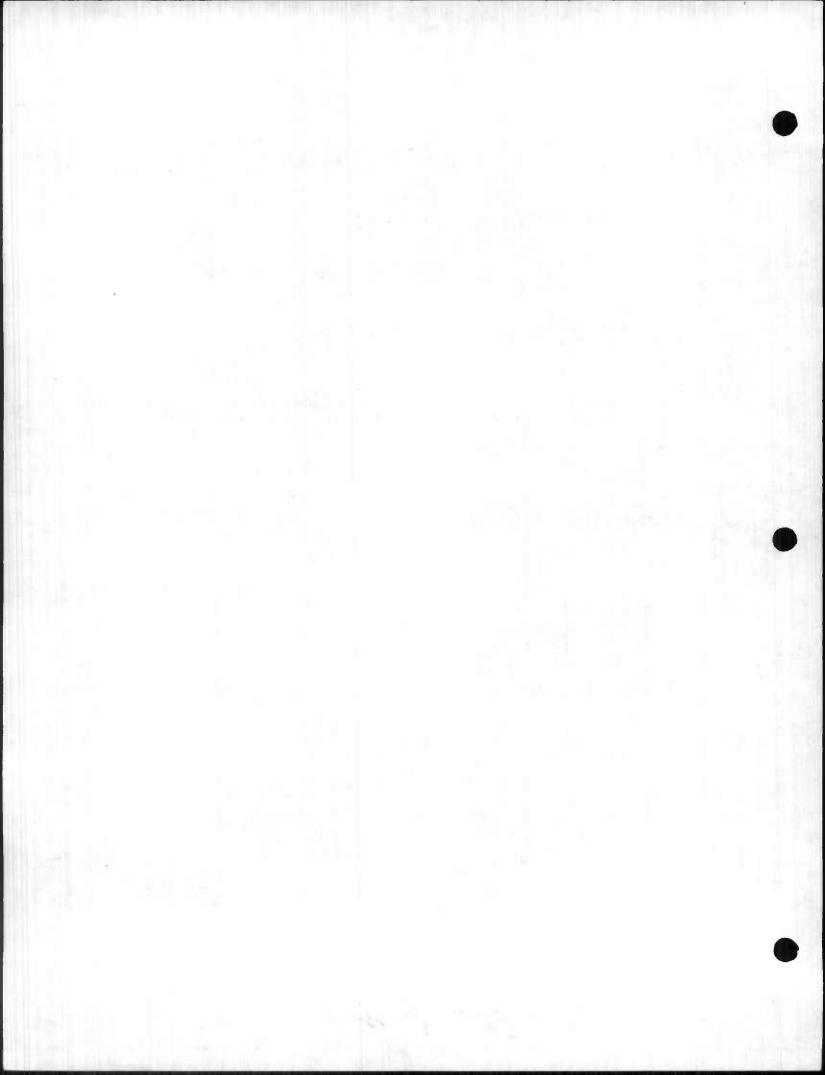


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State of Maryland / Department of Health and Mental Hygiene

| | 1. Deced | ent's Name | e (First, Mid | idia, Las | st) | | | | F 1 - 1 | | | - | 2. Date of D | Reg. No | | | 3. Time of | Death |
|--|---|--|---|------------|--|--|--|--|--|-------------------------------------|--|-----------------------|---|---|--|---|--|--|
| hysician | R | OENA | a f | PIER | RCE | | | | | | | | Month FFRDIII | 10V | | Year 2000 | 12:3 | 7 pm |
| /Medical xaminer | | | f not instituti | | | number) | | | | | 4b. City, Tov | vn, or Lo | cation of De | ath 40 | c. County | | 12 | |
| Adminic; | 11, | ARBI | OR + | HOS | PITA | L CE | NTE | R | | | BAL | TIL | IORE | | N/ | /A | | |
| neral ector | 216- | Security No. | 46 | 6. Se | ex □ M 21501 | | (In yrs. k | est birthday, Yrs. |) If Unde Months | Deys | If Under 2 Hours | 24 Hrs. Min. | 8. Date of E (Month, I FEB. | Birth Day, Year 5, 19 | 28 | Counti | ace (Steta o ry) VIRGI: | |
| | Usual Re | | Decedent 10b. Coun | after. | | | 100 City | , Town or L | ocation | | | | | | | 10 | d. Inside Ci | . I inite |
| or season | MARY | | ANNE | | MDET | | | LEN B | | 7 | | | | | | 10 | 1 ☐ Yes | |
| be notified. | | et and Nun | | ARU | INDER | | | FLEN E | | p Code | | | | 10a C | itizon of V | What Count | n/2 | |
| B B | | | BROO | K DR | | | | | | 210 | | 1 | | | U.S. | Α. | | |
| Examiner ms | | lever Marri | ied 2 Ma | | Armed | Decedent Ever Forces? Ses 2 No. Give or Dates: | | | Was Dece If Yes, spe 1 Yes | | lispanic Orig an, Mexican Specify: | jin? (Spe , Puerto | ecify Yes or t Rican, etc.) | No- | Blec | e - America k, White, e | itc. | |
| c, the Medical. | Elemei | | 15. Decede ify only high ndery (0-12) | hast grad | de complete | ed) je (1-4or 5+ |) | (Give | DO NOT | ork done | durina most | of worki | ing | 16b. I | | usiness/Inde | | |
| | 17. Fathe | | (First, Middle | e, Last) | | | | DINDK | (EI | | 18. Mother | r's Nama | (First, Midd | le, Maide | | | , | |
| o Be | GILB | | | | | | DII | LEY | | | VE | RSIE | | | | LEWIS | 3 | |
| - | | | me/Relation | nship (7 | ype, Print) | | | 19b. Maili | ling Addres | s (Street | | | I Route Num | ber, City | or Town, | Stata, Zip | Code) | 100 |
| | SHAR | I LYN | N MIT | CHEL | L (I | DAUGHT | ER) | 206 | 3RD A | AVENU | JE, S. | W., | GLEN I | BURNI | Œ, M | D. 21 | 061 | |
| 6 | | nod of Disp | | | | | | ece of Disponentery, cre | | | ce) | | Dete | 20c. L | Location - | City or Tov | vn, Steta | |
| 20 | | | ☐ Cremetion 5 ☐ Other (| | | om Steta | | DAR HI | | | 1 | 12 | /16/ 000 | BRC | OKLY | N PAR | K, MD | |
| any inju | 21. Signa | atura of Fur | naral Sarvic | e Licens | see | - / / | | | | | ss of Facility | OTY | GLETO | | | | | |
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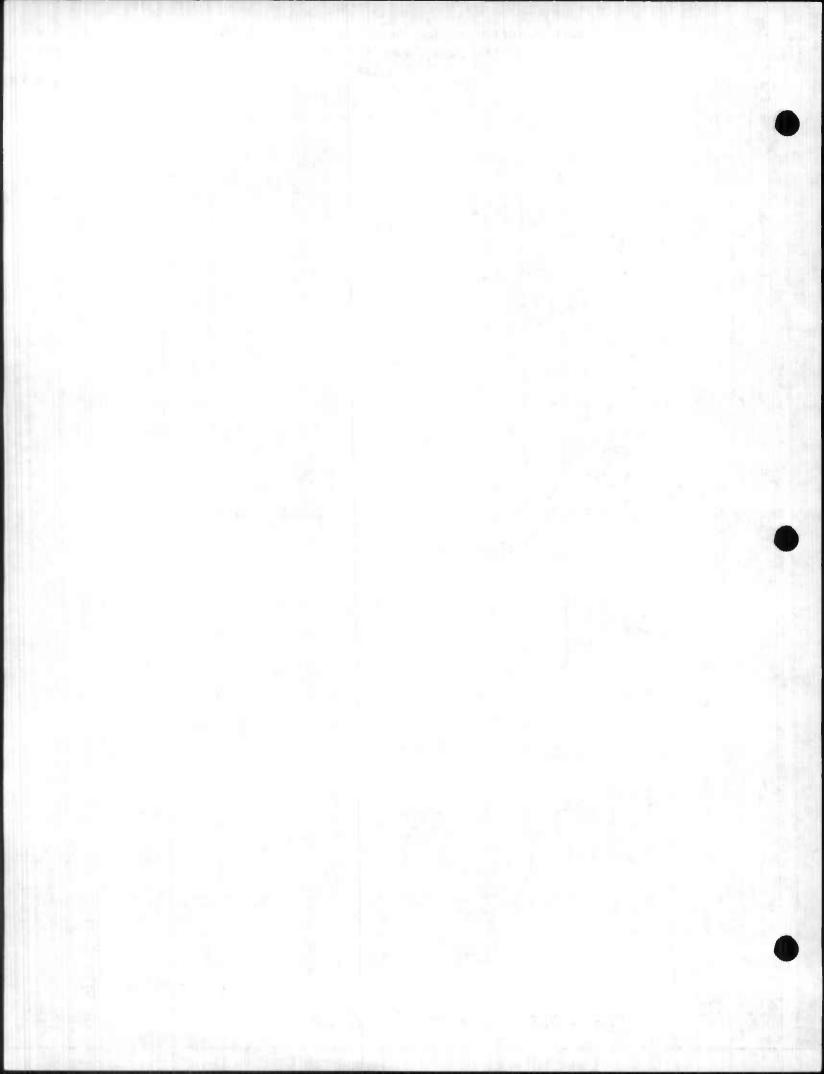
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Please Type or Print in Biack Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician ROGERS 1449 FAY 02 09 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL SYSTEM BALTIMORE CITY UNINERSITY OF 5. Social Security Number MARYLAND If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours 79 Director Balto. 214-14-8390 the Meryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yas 2 No Md. Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with 21136 USA 300 Academy Ave. Funeral Nome 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Bace - American Indian than "natural", or Nen Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: Be Completed by 3 N Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filled within nent of Health end Mentel Hyglene. ant: If Item 27 is marked other than ary or other treumstic event, or Me Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cafeteria Manager 12 Grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Harold Keenan Sadie Appleby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33060 Pompano Beach, Florida (Daughter) 461 S. East 15th Ave. Dora Carolyn White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State pemit. Pege Department of Important: If eny injury or page. 4 Donation 5 Other (Specify) Parkwood Cemetery 2/15/00 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 11824 Reisterstown Road entino leahen m ELINE FUNERAL HOME Reisterstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** HERNIATION SYNDROME /Medical Immediate Cause (Final disease or condition resulting in death) Examiner CERETED VASCULAR ACCIDEN Physician/Medical Examiner hysicien end the burlei-transit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physicien Due to (or as a consequence of): 180 080 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? pege 2 1 Ves 2 No 200 No certificate 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation s efter deeth. 1 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 3 4 ☐ Homicide filled in To the Hospital o within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifie yeseldmoo (Check only one) 29b. Signature and the of certifier 29c. License number MD 29d. Date signed (Month, Day, Year) 12452 2000

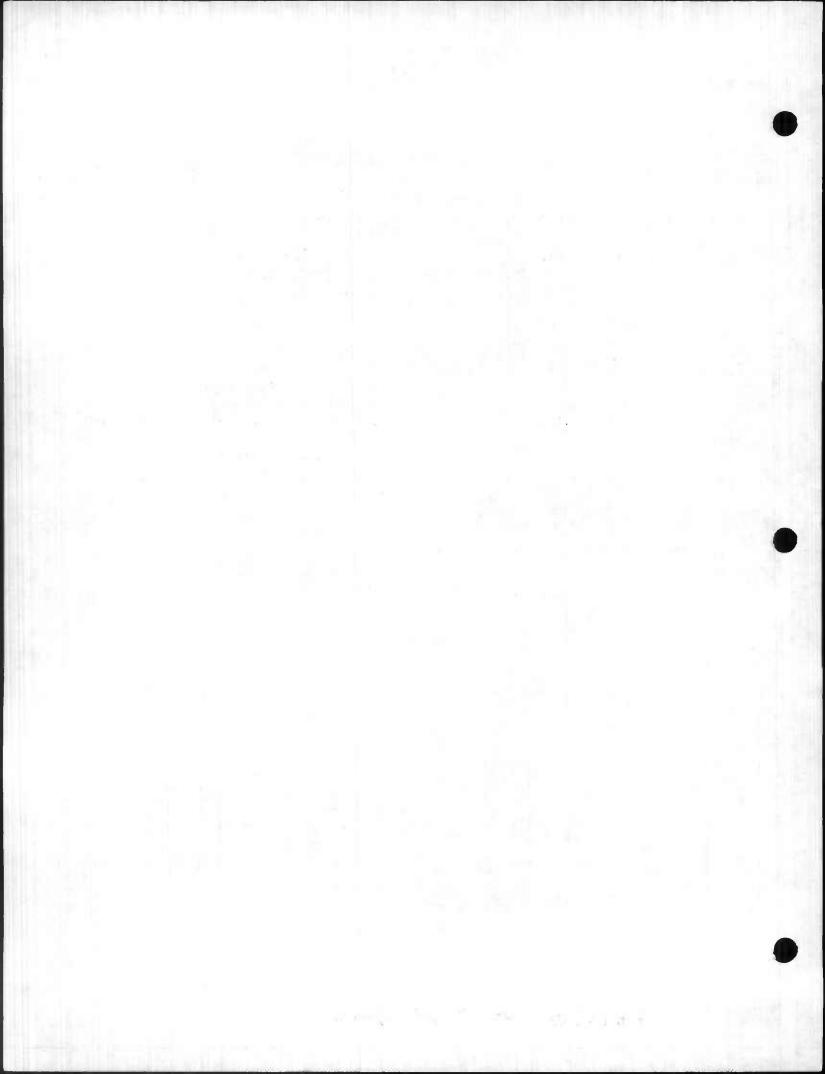
State Registrar 31. Date filed (Month, Day, Year)

FEB 1 4 2000

SOMERVILLE
Registrar's Signature

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

pouls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#1 perPHYG792 2/1/2001 EW 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day February 2, Physician 7:30 PM SHIRLEY SMOTHERS Strothers /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Montgomery SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Yrs. Director 69 July 7, 1930 578-56-9642 unknown Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Montgomery Bethesda 1 Yes 2X No Director herns 23s or 25s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Grovesnor Lane 20814 USA Funeral 11. Maritel Stetus unknown Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datea: 1 Never Married 2 Married b 1 Yes 2√ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Department of Health and Mental Important: If Itam 27 is marked or any injury or other traumatic eve unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Suburban Hospital 8600 Old Georgetown Rd Bethesda, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee

Joseph B. Van Sapt 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Sent 21201 Baltimore, MD 23a. Pert1. Effer the disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final reumonia disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditiona, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last and Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the a 23b. Did tobacco usa contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown mentio Completed by 24b. Were autopsy findings available prior to 24a. Wea an autopsy performed? completion of cause of death? has 20 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: funeral director, Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) No No Hospital: \ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA this or Attending Ph. after death. Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Naturai
Accident 1 Yes 2 No completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, STRUTHERS,

21215-0020

Maryland

altimore,

State Registrar

(Check only one)

29b. Signature and title of certifier

9410 0/4

Bether & 140 20814 George town

29c. License number

29d. Date signed (Month, Day, Year)

Johalnan 31. Date filed (Month, Dey, Year) 32. Registrar'a Signature FEB 1 4 2000

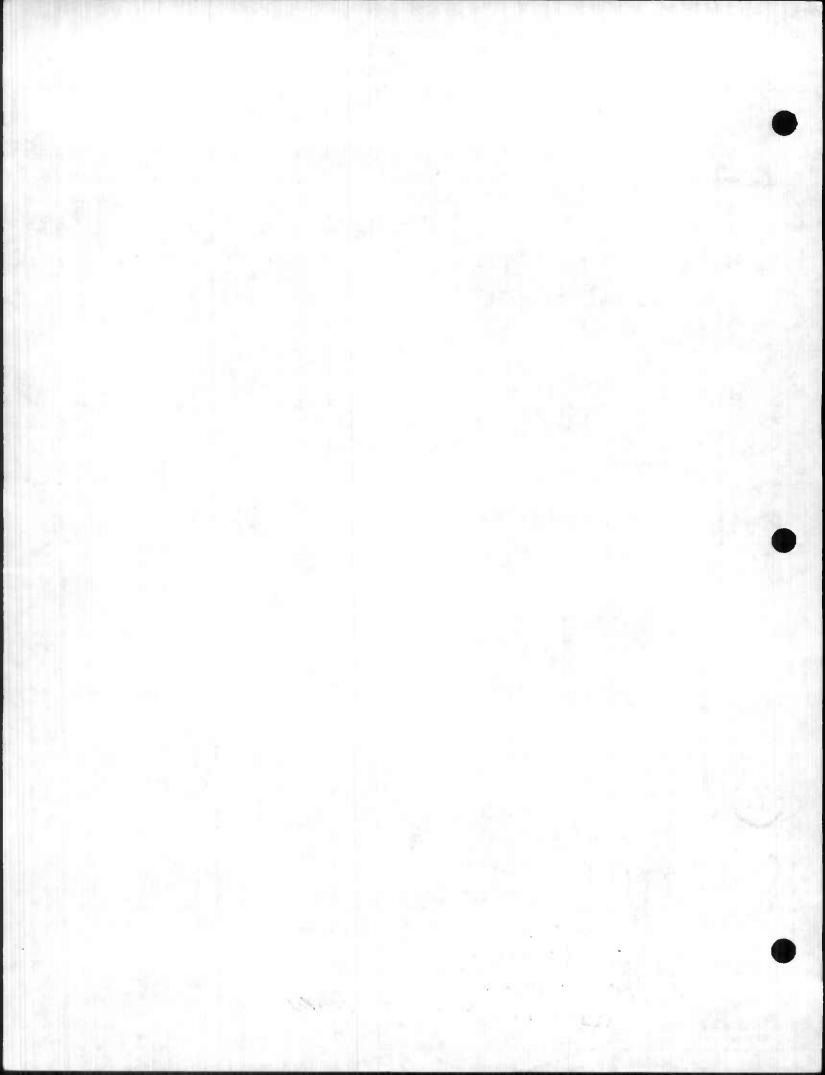
30. Name and address, of person who completed ceuse of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

VIVIAN SANSON State of Maryland Department of Health and Mental Hygiene 00 04 3 7 3

| ## Facility Name (if not institution, give sired and number) ### BAVVIEW MEDICAL CENTER ### BAVVIEW MEDICAL COUNTY ### BAVVIEW MEDICAL COUNT | Physician | Decedent's Name (First, Middle, Las V V A N | SANS | ON | | | 2. Date of Deat Month | Dey | 3. Time of Death 2:40 PM |
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| The state of the s | /Medical Examiner | 4e Facility Name (If not institution, give | street and number) | | | | Location of Death | T | |
| 100. State and Number Country? 100. State and Number of Real State Country. 100. State and State Country Country. 100. State and State Country. 100. State Country. 100. State | | 220-80-3349 11 | | and briting | | | . (Month, Dey, | Year), 1962 | 9. Birthplace (State or Foreign Country) VIRGINIA |
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| Class Control Control Class Clas | the notification of the contraction of the contract | 10e. Street and Number | PLACANT | 10f. | Zip Code | | | | - 0 |
| 19. Informer's Name Print Mode, Lab SHIFFLETT 19. Informer's Name Print Mode, Mark Shiff LETT 19. Informer's Name Print Mode, Mark Shiff LETT 19. Informer's Name Printed control (Type, Print) 19. Melling Address (Street and Mumber or Parist Route Number, City or Town, Stella, 2p Code) N. A. S. A. | | 11. Merital Status 1 Never Married 2 Merried | 12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give | S. 13. Was De If Yes, s | cedent of h | Hispanic Origin? (an, Mexican, Pue | | Black | , White, etc. |
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| Securing | | 12+4 | College (1-4or 5+) | | | Ker | | | |
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| 20e Melhod of Disposition Comment of Superior Comment of Com | 7 is me trauma | 0 | | | | | | | |
| 21. Signature of Funeral Service Licensee 22. Name and Addyrys of Pacity To place of Date of County (1) and the County of County (1) and the County of Coun | and it from 2 my or other | 20a. Method of Disposition 1 D Burial 2 Cremetion 3 D | Removel from State | lece of Disposition (/ | Verne of or other ple | ce) | Dete | | |
| Sequentially list conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions are consequence of list and peer the conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. Other significant conditions contribute to the cause of death of the list of the cause of death of the cause | and and and and and and and and and and | 21. Signature of Funeral Service Licens | C. Connel | 22. Neme CO1 71(0 | | | eral Ho | _ | |
| disease or condition The first of the part | 23a. Part 1. Enter the disease, or heart failure. List only of | lications thet caused the deeth one cause on each line. | n. or enter the m | ode of dyi | ng, such es cardi | ec or respiretory arre | est, | Intervel Between |
| Cause (Disease or Influent feath) Last Due to (or es e consequence of): Cause Ca | kaminer | disease or condition | a | | | NTOXICAT: | ION | | 1 |
| Cause (Disease or Influence that Influence devents resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Cause (Disease or Influence that Influe | al-transit xamine | Sequentially list conditions, if any, leading to immediate | b. Due to (o | r es e consequence (| of): | | | 1 1 1 1 1 | |
| 1 Yee 2 No 3 Probably 4 Unknown and the state of person who completed cause of death out not resulting in the didentying cause given in Peri 1. 1 Yee 2 No 3 Probably 4 Unknown and the state of period of cause of death? | as the burner of Aedical | cause. Enter underlying Cause (Disease or Injury thet initieted events resulting in death) Last | cDue to (or | es e consequence o | f): | | | | |
| 24a. Wes an autopsy performed? 24a. Wes an autopsy performed? 24b. Were autopsy finding evallable prior to completion of cause of death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 27. Menner of Death 1 Netural 5 Pending investigation 28a. Dete of Injury 28b. Time of Injury of Work? 28c. Injury et Work? 28d. Describe how injury occurred 28d. De | e attended for us | Pert II. Other significant conditions co | ntributing to death but not rest | ulting in the underlyin | g cause gi | ven in Pert I. | 23b. Did to | bacco use cont | ribute to the cause of death |
| 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 27. Menner of Death Neutral | detach detach | | | | | | 1 🗆 Y | •• 2□No | 3 Probably 4 Unknow |
| 25. Was case referred to medical examiner? Mayes 2 No | s been sign 2 should be pleted by | | | | | | 24a. Wes a perform | n autopsy ned? | completion of cause |
| Control of the cont | | | | | | | A | es 2 No | Yes 2□ No |
| 27. Menner of Death 1 Netural 28a. Dete of Injury 28b. Time | 9 0 | examiner? | Hospital: | EB/Outpatient 3□ | DOA Ot | har: | | | (Specify) |
| 29e. Certifier (Check only one) and Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as etated. 29e. Certifier (Check only one) Amedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier (Check only one) Amedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as etated. 29e. Signature and title of certifier O. C. M. E. 29d. Date signed (Month, Day, Year) JANUARY 28, 2000 30. Name and edgress of person who completed cause of death (Item 23s) (Type, Print) | 2.5 | 27. Menner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inju | ry et ork? | 28d. Describe ho | ow injury occurre | |
| 29e. Certifier (Check only one) Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as etated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JANUARY 28, 2000 | Director: A d in by the f | 3 Suicide 6 Could not be | 28e. Plece of Injury - At ho | ome, ferm, street, fec | | J Yes 2 X No | 28f. Location (Si City or Town | reet and Number, State) 220 | |
| 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) | Fumera Fumera Tely fille Ilcaf C | (Check only Q Medical Exam | ner: On the basia of examinet | wledge, death occurr tion and/or investigate | ed at the ti | ime, date and pla opinion, death oc | ce, end due to the c | suse(s) and man | ner as stated. |
| 30. Name and edgress of person who completed cause of death (Item 23s) (Type, Print) | To the comple | 310 | and manner steted. | | 29c. Licen: | se number | | 9d. Date signed | (Month, Day, Year) |
| 1 (M) (M) III Felli Street, Darthore, Parviola 21201 | | 30. Name and eddress of person who c | ompleted cause of death (Item | 23a) (Type, Print) Penn Stre | et, I | Baltimor | e, Marvla | nd 21201 | 75 1/4 - 5 |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#17 PER F.H. G780 2-24-2000 JAB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Feb. 12, Marie Grace Skipper 2000 5:15 am 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chapel Hill Convalescent Home Randallstown Baltimore Months Days Hours Min. Set Dete of Birth (Month, Day, Year)

9. Birthplace (State (Month, Day, Year))

9. Birthplace (State (Month, Day, Year))

9. Birthplace (State (Month, Day, Year))

9. Birthplace (State (Month)) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 89 Yrs. 5. Social Security Number 1□ M 20 F 217-03-7781 Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2√ No Md. Baltimore Owings Mills 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 9401 Groff's Mill Drive 21117 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Insurance 17. Father's Name (First, Middle, Last) SEIBERT 18. Mother's Neme (First, Middle, Maiden Sumame) Bradley Edward Sievert Grace Mae Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Kahline - Niece 9401 Groff's Mill Dr., Owings Mills, Md. 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Sater's Church Cem. Feb. 14,2000 Lutherville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service License Eckhardt Funeral Chapel 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md. Approximate Interval Between Onset and Death Immediate Cause (Fine) 1gea disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No 1 Yes 2 0 No 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No

physician and s the buriai-transit The law requires that the death certificate be executed P.O. Box 68760, signed by the a Division of Vital Records. should certificata Mospital or Atlanding Physician:
 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ite any Injury or other traumatic avent, the Medical Examina once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

death

Director

Funeral

é

Completed

Be

2

Physician/Medical Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Completed by 89 25. Was case referred to medical examiner? 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 Anatural 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

10 State Registrar

completely

Within 2 To the

25

man 5 free d 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Resdenden

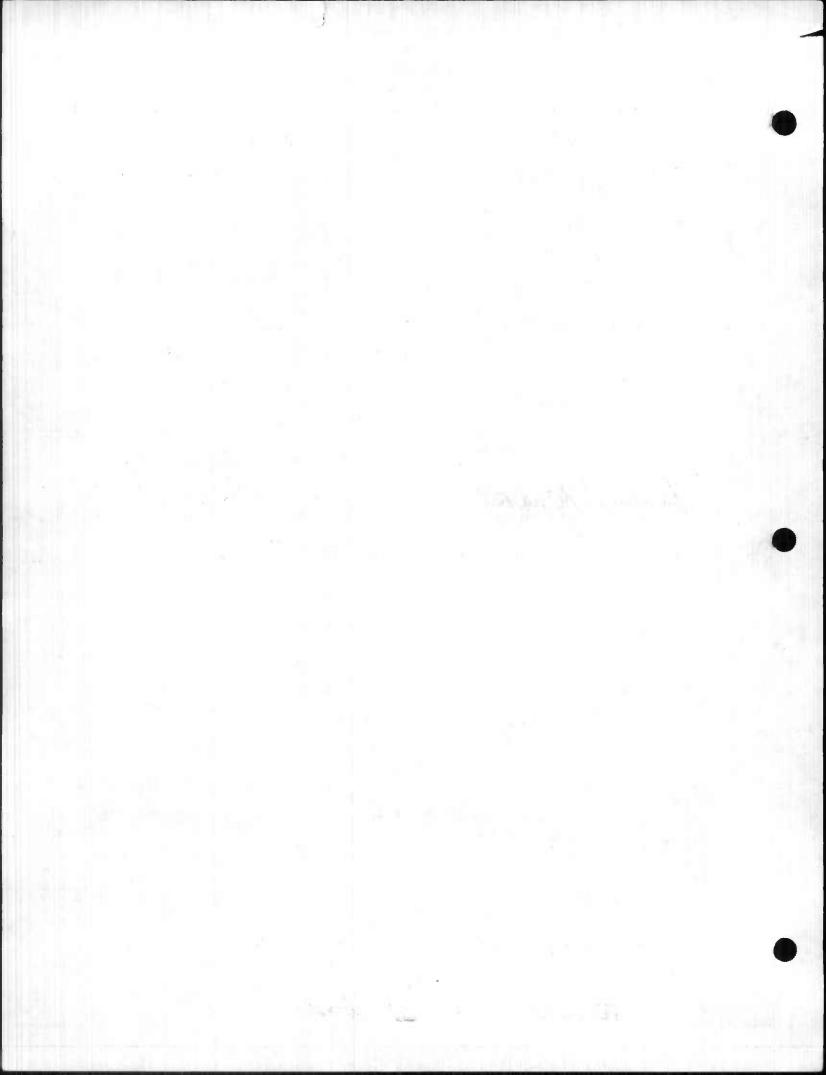
2000

- 1. i tr TI II THE SE ... The state of t

Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene

| | | | , | Cei | rtificate of | Death | R | eg. No. | 0 (| 14375 |
|----------------|---|--|---|------------------------|---|---|---|------------------|-------------------------------------|---|
| ľ | Dhoolalan | 1. Decedent's Neme (First, Middle, Last, |) | | | | 2. Date of Deat Month | h Day | Year | 3. Time of Death |
| | Physician /Medical | ROBERT CHR | RISTOPHER SCF | RANTON | | | Februar | | | 1:15PM |
|) | Examiner | 4a Facility Name (If not institution, give | | | | 4b. City, Town, or L | | 4c. County | | |
| | 4 | 6831 Queens Fe | | | With day of Ware | Baltimo | | Balt | imore | |
| | Funeral Director | 5. Social Security Number 6. Se. 214–30–2734 XX | 7. Age (In yrs. la | Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, October 5 | , 1932 | 9. Birthpl Count Conne | lace (State or Foreign try) ecticut |
| | fand fand | 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10 | 0d. Inside City Limits |
| | Man To | Maryland Baltimore | Ba | ltimore | | | | | | 1 ☐ Yes 2 ☐ No |
| | or 28a-f s | 10e. Street and Number | | 20211101 | 10f. Zip Code | | 1 | 0g. Citizen of W | hat Count | |
| | 23a 23a ral [| 6831 Queens Ferry Road | | | 21239 | | | USA | | |
| 21215-0020 | 72 hours after death with the Maryland "natural", or flama 23a or 28s-1 show after Emylper must be notified at leted by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U,S Armed Forces? 1 Wyes 2 No 53-9 If Yes, Give Year or Dates: | 22 | Wes Decedent of I f Yes, specify Cub 1 ☐ Yes 🔌 💢 No | dispanic Origin? (Span, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | Black | - America k, White, e : White | etc. |
| 5-0 | ed within 72 ho yglene. or than "naturn ft, the transcell Completed | 15. Decedent's Edu (Specify only highest grad | | 16a. Deced | dent's Usual Occup | pation during most of work | sing | 16b. Kind of Bu | siness/Ind | ustry |
| 121 | within then. | Elementary/Secondary (0-12) | College (1-4or 5+) | life. i | DO NOT use retire | d) | | | | |
| 12 | illed v | 17. Father's Neme (First, Middle, Last) | 4 | Dep | uty Direct | 18. Mother's Nam | a (First Middle I | U.S.Army | | |
| Maryland | Saby W | Thomas Nelson | | | | | Nelson | neiden Sumenn | 6/ | |
| Z | should nd Men merke | 19a. tnformant's Neme/Reletionship (Ty | me Print) | 19b Mailir | ng Address (Street | and Number or Ru | | City or Town | State Zio | Codel |
| Ma | 0 4 5 6 | Mary M Scranton | Wife | | | y Road Balt | | | | 0000) |
| re, | f Health from 27 other tr | 20a. Method of Disposition | 0.00 | ace of Dispo | sition (Name of metory or other ple | cal | Date | 20c. Location - | City or To | wn, Stata |
| mo | Pages net of ret: If he rry or o | Marial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | temoval from State | | | al Gardens | 2/15/00 L | uthervill | e. Man | ryland |
| Baitimore | permit. Peg Department Important: I any injury o | 21. Signature of Funeral Service Lidense | | - | . Name and Addre | on of Facility | tchell-Wie | | | |
| m | 88558 | Merines Offe | na Ris | | 6500 Y | ork Road B | | | | Tule IIC. |
| | | 23a. Pert1. Enter the disease, or complishock, or heert failure. List only or | ications that caused the death. | . Do not ent | | | | | | Approximate Interval Between |
| | Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or | nsont es a consec | ive Her | nt Fa | ilure | | 1 | Onset and Death |
| | eath certificete be executed attending physician and for use as the burial-transit clan/Medical Examiner | Sequentially list conditions | Due to (or | es a conseq | juence of): | | | | | |
| 0, | ficete be executed g physician and as the burtal-transit edical Examin | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | |
| 68760, | physicies the bus the bus edical | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or : | as a conseq | uenca of): | | | | 1 | |
| | antific sing p | | d | | | | | | 1 | |
| Box | attend for us | | | | | | | | | |
| P.0. | at the death cert of by the attendine etached for use: PhysiciaryM | Part It. Other significant conditions con | itributing to death but not result | lting in the u | nderlying cause gi | ven in Pert t. | | _1_ | | the cause of death? |
| | ss that igned by be deta by Pt | myel | sassplante | 84) | ndrone | | 1 U Y | 2 2 No | 3 Proc | pably 4 □ Unknown |
| Vital Records, | een s hould | 0 | J V 1 | 3 | | - | 24a. Was e perform | | ava | ore autopsy findings ailable prior to mpletion of cause death? |
| R | The law ate has b page 2 s | | | | | | 1 🗆 Ye | es 2 No | 1 | Yes 2□ No |
| Ita | ysicien: The s certificate director, pag fo Be Co | 25. Was case referred to medical | | | | 26. Placa of Dea | th (Check only on | e) | | |
| | 7 9 9 | examiner? | fospital: 1 Inpatient 2 IE | R/Outpatien | nt 3 DOA | ner: 4 Nursing H | ome 5 Reside | ence 6 Othe | er (Specify | 0 |
| n | ding Pt h. After th funera | 27. Menner of Deeth 1 | 28a. Dete of injury (Month, Day Year) | 28b. Time of tnjury | 28c. inju Wo | ry at | 28d. Describe ho | ow injury occurr | ed | |
| Sio | Attending ir death. ector: After by the fune lfication | Accident investigation 3 Suicide 6 Could not be | | | M 1 | Yes 2□No | | | | |
| Division of | tal or Attending P rs after death. al Director: After ti led in by the funers Certification: | 4 Homicide determined | 28e. Place of Injury - At hon building, etc. (Specify) | ne, farm, str | eet, factory, office | | 28f, Location (Si City or Town | | er or Rura | l Route Number, |
| | | 29a. Certifier 12 Certifying Phys | sician: To the best of my know | dada dash | nongred et the t | me date and slace | and due to the | aucole) and ma | aner en ch | niad |
| | Hospita n 24 hours Funeral petely fillex adical C | (Check only one) | ner: On the basis of examination and menner steted. | on and/or in | vestigation, in my | ppinion, deeth occur | red at the time, d | ate end place, a | and due to | the ceuse(s) |
| | Me Me | 29b. Signature and little of certifier | | | 29c. Licens | se number | 2 | 9d. Date signed | (Month, | Day, Year) |
| | | > Fail 1000 | w, mo | | D | 30927 | / | 2/1 | 4/2 | 2000 |
| | NY | 30 Name and address of person who co | impleted cause of death (Item: | 23a) (Type, | Charles | NT A | PATTIM | re mi | 2 | 21204 |
| | State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatu | ure A | 1 las | 41 | 1.110 | | | |
| | Registrar | PED 14 2 | JUU | /~ | jujua | No. | | | | |

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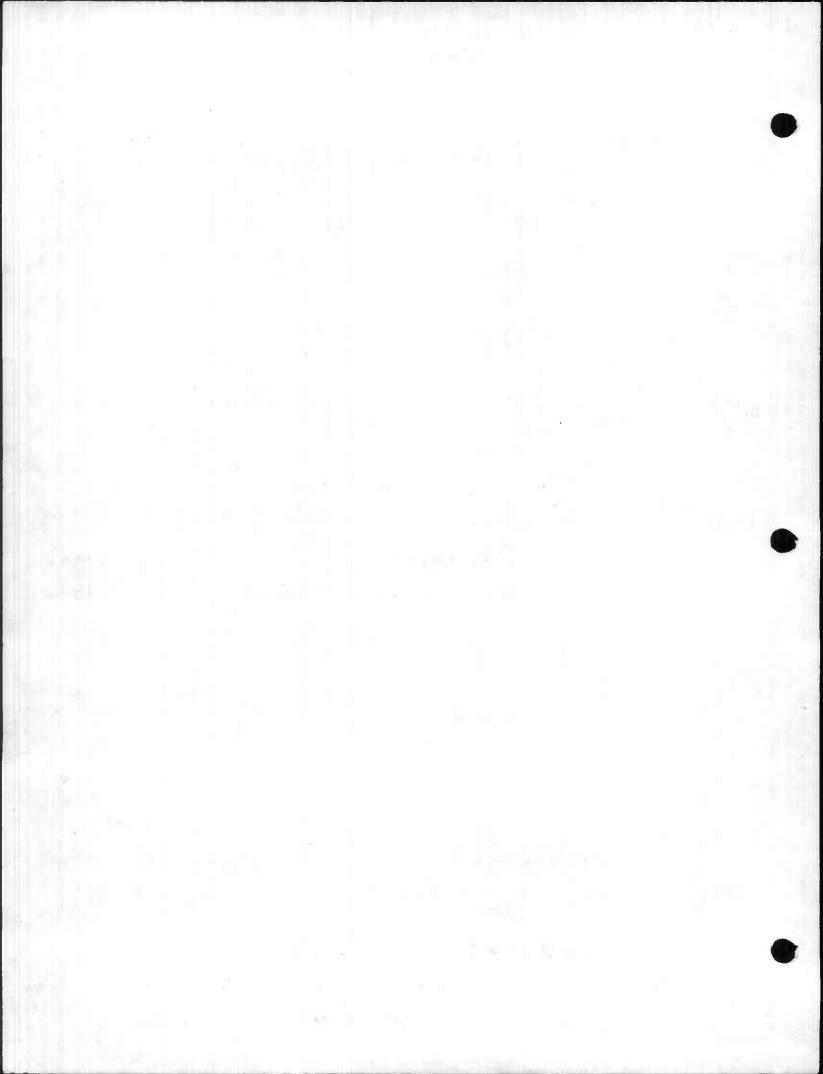


| Baltin | permit. Pa |
|--|--|
| | Phy /N Exa |
| Division of Vital Records, P.O. Box 68760, | pital or Attending Physician: The law requires that the death certificate be executed they death |

Dorothy Jane SHUPP

| | | State of Mary | | artment of l | | nd Mental I | Hygiene () | 0 04376 |
|--|---|---|-------------------------------------|--|--------------------|--|------------------------------------|--|
| | 1. Decedent's Nama (First, Middla, L. | nst) | | | | 2. Date o | Death | Year 3. Time of Death |
| Physician /Medical | DOROTHY SHUPP | | | | | FEBI | RUARY 06, | 2000 11:00AM |
| Examiner | 4a Facility Nama (If not institution, gi | | | | | vn, or Location of E | | |
| | RAVENWOOD LUTHE 5. Social Security Number 6. | | yrs. last birthday | If Under 1 Year | HAGER: | 4 Hrs. 8 Data o | f Birth | INGTON 9 Birthology (State or Foreign |
| Funeral Director | | 1□ M 2X F | 78 Yrs. | Months Days | Hours | Min. Nov | 17, 1921 | Birthplace (State or Foreign Country) MD |
| 2 . | Usual Rasidence of Decedent 10a. Stata 10b. County | 40 | o City Town or I | eastice | | | | 404 Inside Challein |
| taryta t show adat | | ngton | c. City, Town or L Hace | erstown | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| with the Maryland to or 28a-f show be notified at Director | 10e. Street and Number | | 1146 | 10f. Zip Code | | | 10g. Citizen of | A |
| 138 or at be | 1183 Luther Driv | re . | | | 217 | 40 | 1 | USA |
| UZU ours after death with the Maryla ef, or items 23s or 28s-f shor Examiner must be notified at by Funeral Director | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forcas? 1 Yes 2 XNo If Yas, Giva Year or Dates: | r in U,S. 13. | Was Decedent of I If Yes, specify Cub 1 ☐ Yas 2 ☐ No | | in? (Specify Yes o Puerto Rican, atc. | r No- 14. Rac Bia Specifi | ce - American Indian, ck, Whita, etc. |
| 72 hours "naturel", edical Exe | 15. Decedent's E | 234-3-200-3414 | 16a. Deci | edent's Usual Occur | pation | | 16b. Kind of B | usiness/Industry |
| within 72 then 'nu the Media | (Specify only highast gr Elemantary/Secondary (0-12) | completed) College (1-4or 5+) | (Givi | kind of work done DO NOT use retire | during most id) | of working | | |
| N 255 0 | 12 | unknown | | grocery c | 7 | | | ood |
| Viand Wents! H wiced oth site even To Be | 17. Fathar's Nema (First, Middla, Las George Grove | () | | | | rs Name (First, Mi | ddle, Meiden Sumar | ne) |
| To market | 19a. Informant's Name/Ralationship | (Type Print) | 19b Mail | ing Address (Street | | | versore umber, City or Town | State. Zin Code) |
| E 22 48 F | Paul Shupp/husbar | | | Cumberla | | | ear Sprin | |
| of the state | 20a. Mathod of Disposition 1 □ Burlal 2 □ Cremation 3 □ 4 ☒ Donation 5 □ Othar (Speci | Ramoval from Stata | 20b. Place of Disp cemetery, cre | osition (Nama of emetory or other pla | (08) | Date | 20c. Location | - City or Town, Stete |
| Baitimo permit. Page Department. Il important: Il any Injury or ansa. | 21. Signatura of Funaral Sarvice Lice Joseph B | Van Sant | 2 8 | 2. Nama and Address tate Anal altimore | tomy B | oard 655 | W. Baltin | nore Street |
| Physician /Medical | 23a. Pank. Entar tha disaese, or con shock, or heart failure. List only Immediate Ceuse (Final | | death. Do not er | | | | ory arrest, | Approximate Intervel Between Onset and Death |
| Examiner | diseasa or condition rasulting in daath) | . Mem | ionia | • | | | | I week_ |
| je . | | | to (or es a conse | | 10.00 | ml- | | lum. |
| site be executed hysician and the burial-transit | Sequentially list conditions, if any, leeding to immediata causa. Entar Underlying Cause (Diseasa or Injury that initiated events | C | to (or es e conse | quence of): | | <u> </u> | | Jour |
| th certifical ending phy r use as the | resulting in death) Last | d | | | | | 454 | |
| P.O. BOX nat the death cent d by the attendin letached for use | Part II. Other algnificant conditions | contributing to death but ne | ot resulting in the | underlying causa gi | ven in Part I. | 23b. | Did tobacco use co | ontribute to the cause of death? |
| Phy detact | | noue | _ | | | | 1 ☐ Yes 2 ☐ No | 3 Probably 4 Nonknow |
| To Attending Physician: The law requires that the death certification of Attending Physician: The law requires that the death certification has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/Med | | | | | | 24a. | Was an autopsy performed? | 24b. Were autopsy tindings available prior to completion of cause of death? |
| The life has bage | | | | | | | 1□Yes 2ENo | 1 ☐ Yes ♠ No |
| vital necoving section. The law director, page 2 s | 25. Was case rafarred to medical axaminar? | | | | | of Death (Check of | only one) | 1 |
| Physician: This certific and director, | 1 ☐ Yes 2 ② No | Hospitat: | 2 ER/Outpatie | INT 3LI DOA | 9.1 | - | Residence 6 □Otl | |
| To the Hospital or Attending Physician: The is within & A hours after death. To the Funeral Director: After this centricate ha completely filled in by the funeral director, page. Medical Certification: To Be Com | 27. Mannar of Death Panding 5 Panding 2 Accident invastigation 3 Suicida 6 Could not be | De Diese of Injury | | M 1 | Yas 2□N | No | ribe how injury occur | ber or Rural Route Number, |
| DIV oltal or A urs after real Directified in D | 4 Homicide datemined | building, etc. (S | Specify) | | | City o | r Town, Stete) | |
| To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b. Medical Certif | (Check only 2 Medical Exa | hysician: To the best of m miner: On the basis of exe and mannar stated | minetion and/or is | nvestigation, in my | opinion, deet | place, and due to h occurred at the t | ime, date and place, | and due to the cause(s) |
| To the Com | 29b. Signature and title of cartifier | g shap | | | Se number | - | 29d. Data signe 2 - 6 | ed (Month, Day, Year) |
| State | 30. Name and address of person who MAW2AA. 31. Data filed (Month, Day, Year) | Completed causa of death JSIAPI 32. Registrar's | 368 F | TICL ST | reat | HAGE. | NS70wn | 21740 ما ا |
| Registrar | FEB14 | 2000 Den | we p | 4 Apa | Ms | | | |

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene

1X Yes 2 □ No

| | п |
|-----------|----|
| Physician | ı |
| /Medical | ļ. |
| Examiner | ı |
| | ı |

Parker Vernon Skipper, Jr.

3. Time of Death 2000 1:07 P.M.

Funeral Director

r than "natural", or items 23s or 28s-f show the Medical Esseviner must be notified at filed within 72 hours after

Funeral Directo

Be Completed by

7 is marked other treumatic event, permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth any Injury or other treumatic event pots.

Baitimore. Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

The lew requires that the death certificate be executed the burial-trens Box 68760. P.O. detached à of Vital Records. page 2 or Attending Physicien: this Division after death.

Certificate of Death 2. Dale of Death 1. Decedent's Name (First, Middle, Last) Month 24, January PARKER V. SKIPPER JR 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) 3503 Pelham Avenue, 1st Floor Apartment Baltimore N/A 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Deys 1 MM 2□ F March 27, 1921 unknown unknown Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 3503 Pelham Ave 1st flr 14. Race - American Indien, Bleck, White, etc. 11, Merital Stetus unknown 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 | Yes 2 | No If Yes, Give Year or Dates: unknown 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) UNKNOWN unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) unknown unknown 19b, Majling Address (Street end Number or Rural Route Number City or Town State, Zip Code)
111 Penn Street Baltimore, MD 21201 19e. Informant's Neme/Relationship (Type, Print) O.C.M.E. 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 🖔 Other (Specify) 21. Signature of Euneral Service Licensee
Joseph B Van Sant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Carlinasarlar Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en autopsy performed? partial Yes 2 No 24b. Were eutopsy tindings eveilable prior to completion of cause of death? Yes 2 No

Approximete Interval Betw Onset end Deeth

25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Mepner of Death 28b. Time of 28d. Describe how injury occurred 5 Panding Injury 1 ☐ Yes 2 ☐ No

1/2 Natural 2 Accident investigetion 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 WMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. 29b. Signeture and title of certified

29c. License number O.C.M.E.

29d. Dete signed (Month, Day, Year) January 25, 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Vennis 5 huten

111 Penn Street, Baltimore, Maryland 21201 sach

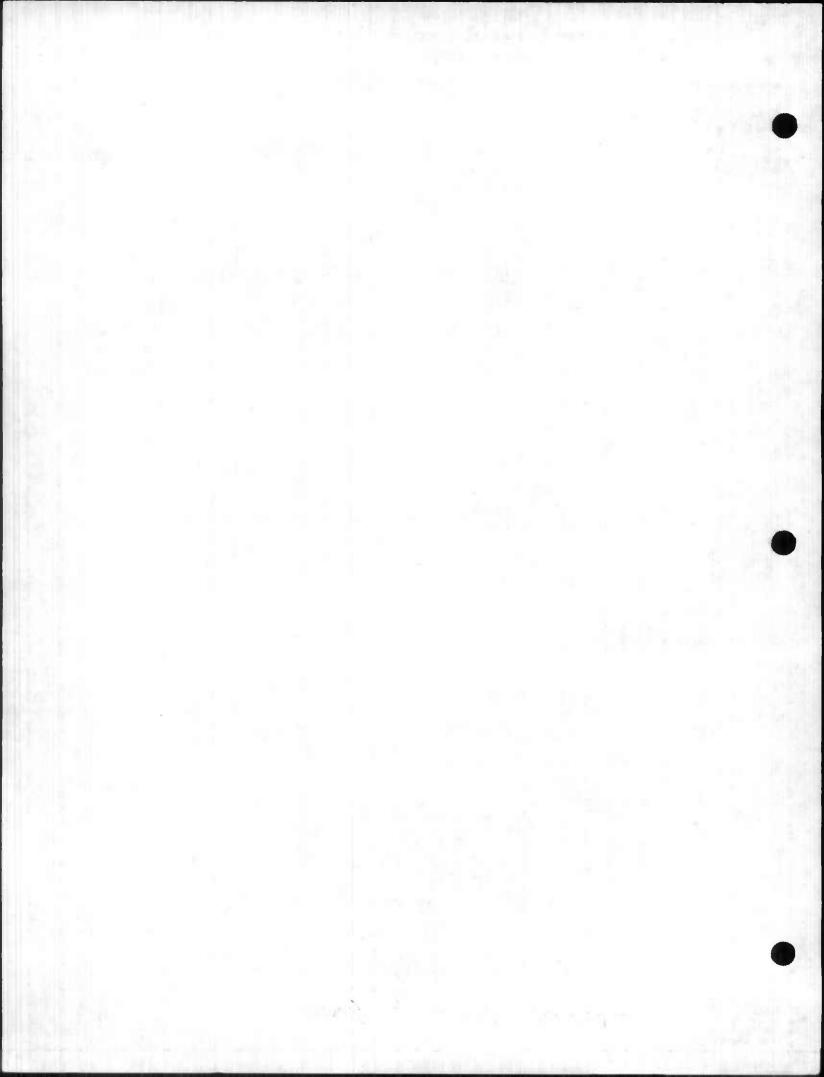
31. Dete filed (Month, Day, Year) FEB 14 2000 32. Registrar's Signature

DHMH 16 Rav 6/95

filled in by

24 hours Hospital

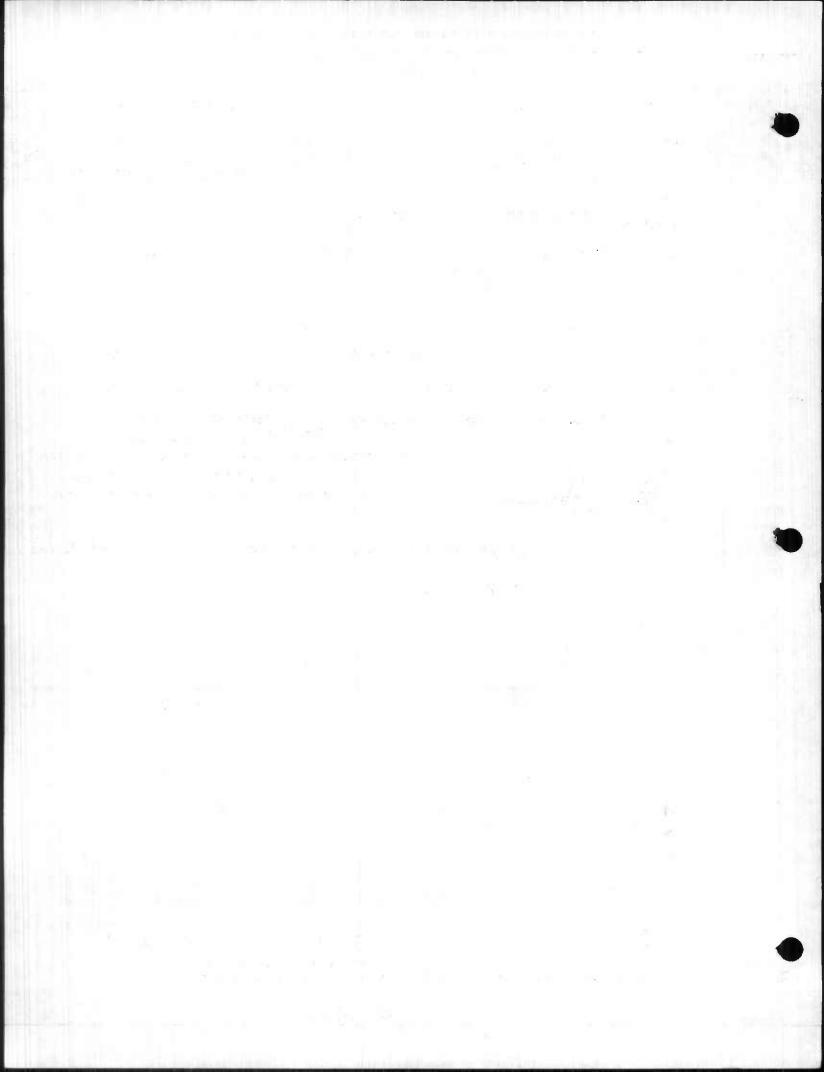
To the Within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

| | 1. | Decedent's Neme (| First, Middle, La | ist) | | | rtificate | | | 2. Date of D | Reg. No. | | 3. Time of De | eath |
|---|---------------------------|--|--|---|---|--|--|---------------------------------|--|---|--|--|---|--------------|
| nysician Medicai | | ELLEN | | MARIE TAYLO | | | | | | Month FEBRUA | ARY 10. | Day Year | | 2:45 PM |
| cai | 4e | 4e. Fecllity Neme (If not institution, give street and number) | | | | 41 | | | 4b. City, Town, or Location of Dec | | | | | |
| | ı | 104 2ND A | AVENUE. | N. | | | | | FERNDA | LE | ANN | E ARU | NDEL | |
| Г | 5. | Sociel Security Num | nber 6. S | | | lest birthday) | If Under 1 Months | | If Under 24 Hrs Hours Min. | | irth Dev. Year) | 9. Birth | place (State or F | oreign |
| | - | 213-30-77 | 727 | I M EEP | 66 | Yrs. | | 50,0 | 110010 | | 28, 193 | | | |
| | - | suel Residence of De la. Stete | Ob. County | | 10c. City | y, Town or Lo | ocation | | | | | | 10d. Inside City I | imits |
| ō | | ANNE ARUNDEL | | | | FERNDALE | | | | | | 1 | 1 ☐ Yes 2 | |
| Director | | MARYLAND 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of What Country? | | | intry? | |
| a D | | 104 2ND AVENUE, N. | | | | 21061 | | | 51 | | U.S | U.S.A. | | |
| Funeral | 11 | 11. Marital Status 12. Was Decedent E Armed Forces? | | | | ver in U,S. 13. Was Decedent of | | | f Hispanic Origin? (Specify Yes or Nouban, Mexican, Puerto Rican, etc.) | | | | | |
| | | 1 Never Merried 2 Married 1 Yes 2 N If Yes, Give | | | | 1 □ Yes 2 N | | | | | Black, White, etc. Specify: WHITE | | | |
| d by | L | 3 LI Wildowed 4 LX Divorced Year or Dates: | | | | | | | | эрес | | | | |
| lete | L | Decedent's Education (Specify only highest grade completed) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | | | ation furing most of wo | rking | 16b. Kind of | Business/Ir | ndustry | |
| Completed | | Elementary/Secondary (0-12) College (1-4or 5- | | | or 5+) | | | |) | | | | | |
| | 17 | . Father's Name (Fir | rst, Middle, Last) |) | | HOME | MAKER | | 18. Mother's Ne | me (First, Middle | | WN_HOI | ME | |
| To Be | E | LMER | | E. | McG | EE | | | MARGARE | T | Α. | Tri | HATER | |
| - | - | a. Informant's Name | e/Relationship (| | | T | ng Address (| | and Number or R | | | | | |
| | R | OBERT M. | TAYLOR, | JR. (: | SON) | 104 2 | ND AV | ENUE | E, N., F | ERNDALE | , MD. 2 | 1061 | | |
| | 20 | a. Method of Dispos | | Removal from Sta | | laca of Dispo | sition (Neme | e of G | len Haven | 2/14/ | Glen Bu | n - City or T | own, State | |
| | | 4 Donation 5 | | | | | | | 2000 | | | MARYLAN | D | |
| | 21 | 21. Signature of Joural Service Licensee | | | | 22. Name end Address of Facility SINGLETON FUNERAL HOME, P. | | | | | , P.A., | | | |
| | | Hay. | Has | ۹ | | | | | VENUE, S | | | | | 1 |
| | 2 | 3e. Pert1. Enter the shock, or heart fa | disease, or com ailure. List only | plications that caus | sed the death | . Do not ente | er the mode | of chains | n cuch ac cardia | c or respiratory | arrest | | Approximate | |
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| er | di | nmediate Cause (Fin sease or condition sulting in deeth) | nal | a. M | O C M | Di M | L IN | | | , | oneat, | | Onset end Des | ith |
| miner | re | sease or condition sulting in deeth) | | | Due to (or | Di Mo | Quence of): | | | , | o11631, | | Onset end Des | ith |
| Examiner | re | sease or condition sulting in deeth) | | a. M | Due to (or | Di M | Quence of): | | | , | ollost, | | Onset end Des | ith |
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 04379

| | Decedent's Name (First, Michael Control of the | ddle, Last) | | | Cer | tificat | e of | Death | 2. Date of D | Reg. N | io. | | 3. Time | of Death |
|--|---|---------------------------|---|--|---------------------------|--|--|--|---|-----------------------------------|--------------------------|----------------------------------|---|----------------------------------|
| Physician | LAVERNE EVELYN JONES THOMPSON | | | | | | | | Month FEBRUA | | Day | Year 2000 | 11.3 | 30 A.M. |
| /Medical Examiner | 4a Facility Name (If not institu | | | | | | T | 4b. City, Town, or | | | lc. County | | 11.0 | JO IX. |
| | SAINT JOSEPH | - | | | | -WII-4 | | TOWSON | | B | ALTIM | ORE | | |
| Funeral Director | 5. Social Security Number 219–07–9925 Usual Residence of Decedent | 6. Sex 1□ M 💥 | | e (In yrs. las | Yrs. | If Under Months | Days | | | er 1 | 3,1919 | 9. Birthple Country Mary 1 | ice (State 3) and | le or Foreign |
| M M | 10a. State 10b. Cour | nty | | 10c. City, | Town or Lo | cation | | 2.167/ | | | | 10 | d. Inside | City Limits |
| o Maria | Maryland Balt | imore | | Towson | n | | | | | | | | 1 🗆 Y | as ANNo |
| off with the Ma 23a or 28a-f s ust be notified rel Director | 10a. Street and Number 113 Overcrest Roa | d | | | | 101. Zip 2128 | 36 | | | 10g. Citizen of What Country? USA | | | | |
| VILLE 13-00.CU within 72 hours after death with the Maryland one. The "setural", or herre 23e or 28e-f show he Medical Examiner must be notified at ampleted by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ M 3XX Widowed 4 ☐ Divorce | Arm | s Decedent led Forces? Yes 2/1/1/ es, Give Ir or Dates: | | 2.0 | Was Deced f Yes, spec f □ Yes | | Hispanic Origin? (i ean, Mexican, Pue Specify: | Specify Yes or N rto Rican, etc.) | 0- | | e - America k, White, et | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours at the and Markel Hygional Arabural; or traumatic event, the Medical Exam To Be Completed by F | 15. Deced (Specify only high Elementary/Secondary (0-12 | | leted) ege (1-4or 5 | | (Give | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary County Government | | | | | | | | |
| The Hard | 17, Father's Name (First, Midd | (e. Last) | | | | 260 | creu | | me (First, Middle | | | | ment | |
| yiano wid be in Mental H Mental H afte even To Be | Leonard Jones | | | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Ackerman | | | | | |
| any shou | 19a. Informant's Name/Relation | enship (Type, Prin | nt) | | 19b. Mailin | ng Address | (Stree | t and Number or F | 200- | | y or Town, | State, Zip (| Code) | |
| | Stephen Clark | | Neph | new | 4703 | Woodwa | ay L | ane NW Wash | nington, D | .C. | 20016 | | | |
| Galumore, normal. Pages 1 and Department of Health myortant; if them 27 and injury or other tooks. | 20a. Method of Disposition 1 XX Burial 2 ☐ Crematio Donation 5 ☐ Other | from State | cem | of Disposite of Di | natory or o | ther pla | port of perplace) Prial Park 2/14/00 Elkridge, Maryland | | | | | | | |
| Depart Depart Import any in) | 21. Inhature of Funeral Service | Licensee | No | nak | | | | ess of Facility Mi Road Balti | tchell-Wi | | | | tome | Inc. |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | w | | RESPI | s a conseq | 11. | LLUI | RE | | | | 1 | | |
| filtrate be executed g physician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury cause, (Disease or injury) | | | | | | | | | | | | | |
| | Cause (Disease or injury that initiated events resulting in death) Last | (or as a consequence of): | | | | | | | | | | | | |
| deeth cert deeth cert e attendin ed for use | Part II. Other significant cond | Mana contabution | a to dooth h | ut not rooulting | na in tha cur | adad ina a | 01100 D | una in Dart I | 22h Die | Ltohao | 00 100 000 | ntelbuen to t | the care | se of death? |
| hat the ed by th detach | CARDIAC AR | | y to death bu | at not result | ng at the ut | idenying o | euse gi | Vert in Part I. | | | | | | K Unknown |
| D D D | CORONARY | ARTERY H | EART I | DISEAS | E | | | | 24a. Wa peri | s an au Iormedi | topsy | avai | re autops ilable pric pletion of eath? | sy findings or to of cause |
| The lay page 2 | STATUS PO | ST CORON | ARY BY | YPASS | GRAFT | TNG | | | 17 | Yes | 2□ No | 11 | Yes 2 | P□ No |
| certificate rector, page Co | 25. Was case referred to medi examiner? | cal | | | | | | | ath (Check only | one) | | | | |
| Physician: this certificant director, | 1 ☐ Yes 2 🗶 No | Hospital: | 1 Inpatie | nt 2 EP | | | M | | Home 5 □ Res | | | |) | |
| eath. for: After the fune | 27. Manner of Death 1 Matural 5 Pend 2 Accident inversal Sulcide 6 Coul | ding stigation | Date of Injui (Month, Da) | y Year) | Bb. Time of Injury | М | | rk?]Yes 2 □ No | 28d. Describe | | | | | |
| To the Hospital or All within 24 hours after of <u>To the Euroral Direct</u> completely filled in by Medical Certiff | 4 Homicide dete | mined 288. | building, etc | | | | | | 28f. Location City or To | own, Sta | a(e) | | | rumber, |
| To the Hospital within 24 hours of Total Eureral completely filled | 29a. Certifier 12 Certify (Check only one) | al Examiner: On | the basis of manner sta | examination | idge, death and/or inv | occurred restigation, | at the ti | me, date and plac opinion, death occ | e, and due to the urred at the time | cause , date a | (s) and ma and place, | anner as sta and due to t | ted. the caus | e(s) |
| To the Methin 2 Mec | 29b. Signature and tele of Arti | | 11 | _ | | 290 | . Licen | se number | | 29d. [| Date signe | d (Month, D | lay, Year | r) |
| Min | > Ste | n/(/ | He | MI |). | | D34 | 543 | | | | | | |
| No A | 30. Name and address of person STEVEN R. AX | | | | | | SON | I, MARYLA | ND 2120 | 4 | | | | |
| State Registrar | 31. Date filed (Month, Day, Yea | 4 2000 | 32. Registra | ar's Signatur | 9 6 | 1 1 | par | Ks | | | | | | |

Marine Stranger Comment

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene N Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Deeth TOOMEY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Nama (If not institution, giva street and number) BALTIMORE n/a BON SECOURS HOSPITAL If Under 24 Hrs. 8. Data of Birth North, Pay, Year) FEB. 18, 1929 If Undar 1 Yaer 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthpieca (Stata or Foreign 1□ M 2 TF Deys VIRGINIA 70 217-24-5118 Yrs. Usual Rasidanca of Dacadani 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 No MD. N/A BALTIMORE 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 2833 FREDERICK AVENUE 21223 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacadant's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) Collage (1-4or 5+) WAITRESS WHITE COFFEE POT 17. Fether's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) HARRY WEBB. SR. MARGARET HOFFNAGEL 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERTRUDE McCULLOUGH/FRIEND 2833 FREDERICK AVENUE, BALTIMORE, MARYLAND 21223 20b. Placa of Disposition (Name of cemetary, crematory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Durial 2 Cremation 3 Ramoval from Stata 4 Donetion 5 Othar (Specify) MEADOWRIDGE MEMORIAL 2/12/00 ELKRIDGE, MARYLAND 21. Signature of Funaral Sarvice Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. LILLY & ZEILER INC. FUNERAL HOME Immediata Cause (Final disaasa or condition rasulting in daath) Sequantially list conditions, if eny, laeding to immadiata causa. Entar Undarlying Causa (Diseese or injury that initieted events rasulting in death) Last Part II. Other significant/conditions contributing to death, but not re 23b. Did tobacco use contribute to the cause of death? rultine in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to completion of cause of deeth? 24e. Was en eutopsy performed? 1 Yas 2 No 25. Was casa raferred to medical examinar? 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, or Modical Examine: must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Exempter 2006.

3altimore, Maryland 21215-0020

with the Maryland

Examiner

27. Mannar of Death

1 Naturel 2 Accident

3 Suicida

29a. Cartifiar

4 Homicide

(Check only one)

physician and the burial-transit Physician/Medicai þ Completed Be 10

Box 68760, for use as Division of Vital Records, P.O. or Attending Physician: funeral director, 24 hours after death. Funeral Director: Al

Hospital

To the within 2

Registrar

Medical

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34

| 90. Sign | ature about the | 200 artifler | An | | _ |
|----------|-----------------|--------------|------------|----|-------------|
|). Name | and address | person wh | redisplate | BE | death (Item |

5 Pending

invastigation 6 Could not ba

28c. Injury et Work?

1 Yas 2 No

1 Medicat Examinar: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Bata signad (Month, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

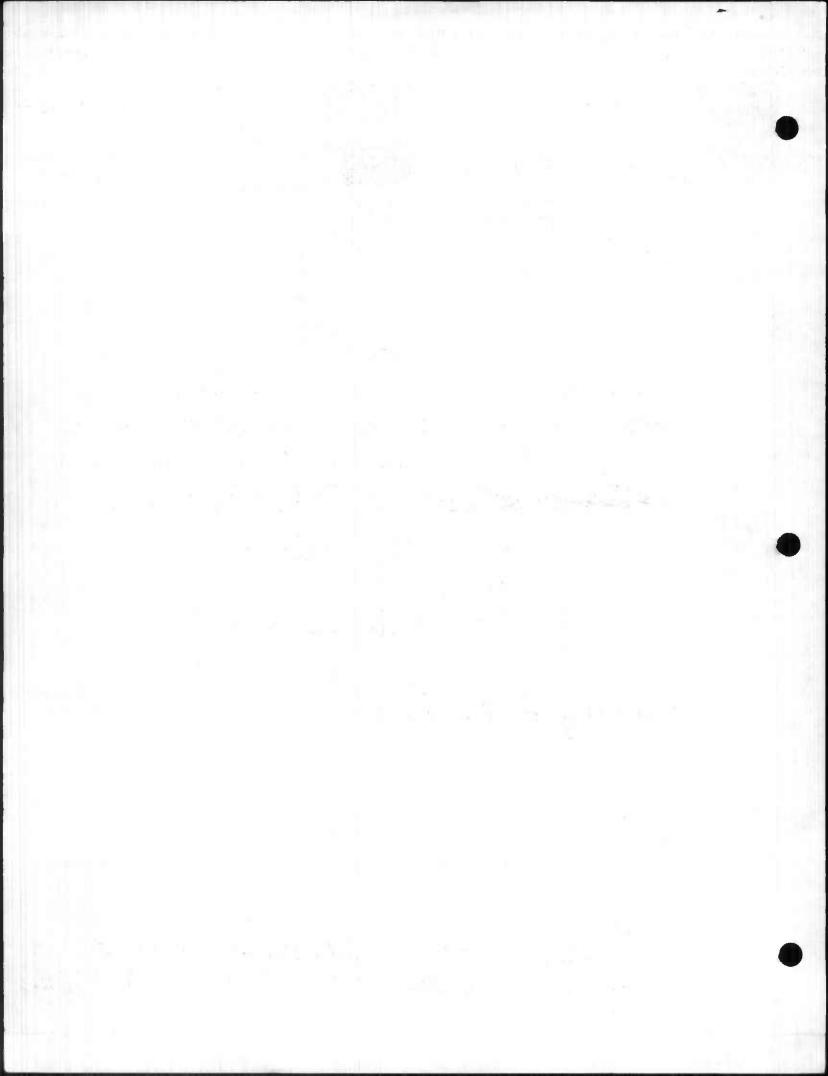
940 W. BALT

28d. Dascribe how Injury occurred

Registrar's Signal

28b. Time of

28a. Pleca of Injury - At homa, farm, street, factory, offica building, atc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedant's Neme (First, Middla, Last) Day Month Vaar FEBRUARY 6, 2000 12:01 AM ARNOLD B. VAUGHT 4b. City, Town, or Location of Daath 4e Facility Name (If not institution, giva street and number) 4c. County of Death Montgomery County General Hospital Olney Montgomery 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) 7. Age (In yrs. last birthday) If Under 1 Year | if Undar 24 Hrs. 5. Social Security Number Deys 1⊠M 2□ F 99 Months Hours Nov 18, 1900 Indiana 133-26-6601 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10h County 1 Yas 2X No MD Montgomery Sandy Springs 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 17330 Quaker Lane 20860 USA 14. Race - Amarican Indian, 12. Wes Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Merried 2 Married white 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Dacedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantary/Sacondary (0-12) College (1-4or 5+) religion

18. Mother's Nama (First, Middla, Meidan Surnema) unknown minister 17. Father's Name (First, Middla, Last) Claude Vaught Mary Barnes 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Ratationship (Typa, Print) SandySprings, MD 20860 17330 Quaker Lane Lois Vaught/spouse 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removei from Stata 4 ☑ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensea
Joseph B, Van Sant 22. Nama and Addrass of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part1. Erffar tha disaasa, or complications that ceusad tha death. Do not anter tha mode of dying, such es cardiac or respiratory arrest, shock, or haart failure. List only one causa on each lina. Approximata Intarvel Between Onsat and Daath Immediata Causa (Final 2 weeks neumonia diseasa or condition resulting in death) Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarfying Causa (Disaasa or Injury that initieted avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or es a consaquance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of ceusa of daath? 2 No 1 Yas 1 Yas 2 No 26. Place of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No

Examiner Examiner physicien and the burial-transit The law requires that the death certificate be executed Physician/Medical ettanding ad by the e Division of Vital Records, P.O. signed by t þ Completed peen has cartificata or Attending Physician: funeral director, Be 2 After this Certification: death. 24 hours after death Funeral Director: illed in by Hospital edical

Physician

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Examiner

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Director

28a-f show

5 items 23a Director

Funeral

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traumatic event, the Medical Examiner must be notified at

"natural", or

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If fem 27 is marked other any Injury or other treumatic event, which

Physician /Medical

filed within 7 Hygiene.

with the Maryland

death

72 hours aftar

Maryland 21215-0020

Baltimore,

25. Was cesa rafarrad to medical axaminar? 1 ☐ Yas > No 27. Mannar of Death 1 Netural 2 Accidant

3 Sulcide 6 Could not be determined 4 Homictde

29a. Cartifier

28a. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the ceuse(s) and mannar as stetad.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, data and place, end due to the cause(s) and mannar stated. 29b. Signeture end title of certifian

29c. Licansa number D23124

29d. Date signed (Month, Day, Year) February

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

M. Hannon MO

MD 1396 PICCARD DRIVE, ROCKVILLE, MARYLAND 20850 DENNIS M. HANNON 31. Data filed (Month, Dey, Yaar)

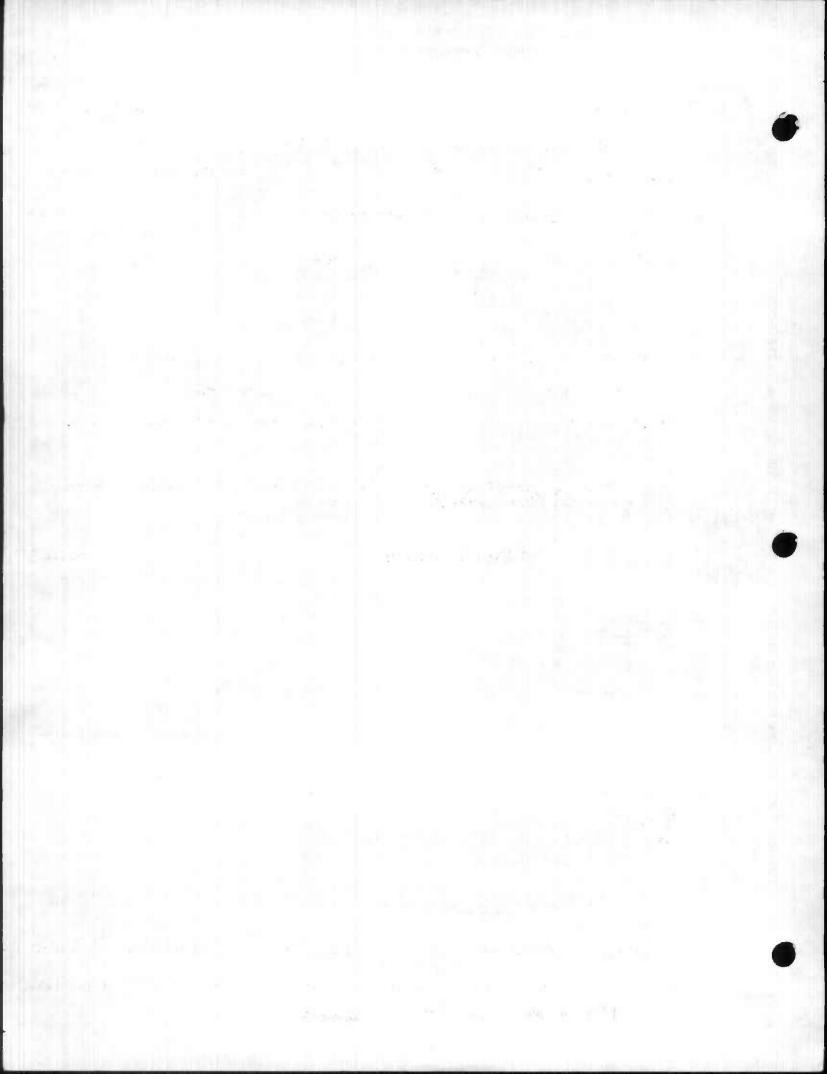
State Registrar

FEB 1 4 2000



DHMH 16 Rev 6/95

To the Vithin 2



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year onnie 10 benary 4b. City, Town, or Location of Deeth 4c. County of Deeth 4s Fecility Neme (If not institution, give street and number, Splfime 8 NA Universión Date of Birth (Month, Day, Year) 10-09-60 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) Deys 10M 20 F 39 212-82-2667 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. fnside City Limits MD NA Baltimore XIXI Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21201 611 N. Paca Street USA Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. . Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 1 ☐ Yes 2 ₺ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 11th Grade College (1-4or 5+) NA various trades Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Linda Barnes William Williams 1.00 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 215 South Ellwood Avenue Baltimore, Maryland Williams Tarnisha 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State MD 20a. Method of Disposition Dete cemetery, crematory or other place) Kings Mem. Pk. Cem. 1 ₺ Buriat 2 Cremetion 3 Removet from Stete 02-14-2000 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Baltimore, Maryland -WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the diseese, or compile shock, or heart tailure. List only on Approximete Intervel Between Onset and Death Do not enter the mode of dying, such es cardiec or respiretory arrest, Endocarch. Immediate Cause (Finet disease or condition resulting in death) Due to (or es e consequence ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24e. Wes en autopsy performed? completion of cause of death? 22 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

Department of Important: If eny injury or pnice.

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland neri of Heelth and Mentel Hyglene.
Instit if them 27 le marked other than "natural", or itema 23a or 23a-f ahow any or other treament overs, the Medical Earthman must be notified at my or other treament overs, the Medical Earthman must be notified at

Baitimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner burlel-transit physician a the burle lor use page 2

Completed by Physician/Medical 8

or Attending Physicien: The lew requires that the deeth certificate be executed certificate funeral director, After this 24 hours efter death. the filled in by Hospital To the Hosp within 24 ho To the Fune

> State Registrar

31. Date filed (Month, Day,

25. Wes case referred to medical examiner? 1 Yes 2 No Certification: To 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated. (Check only one)

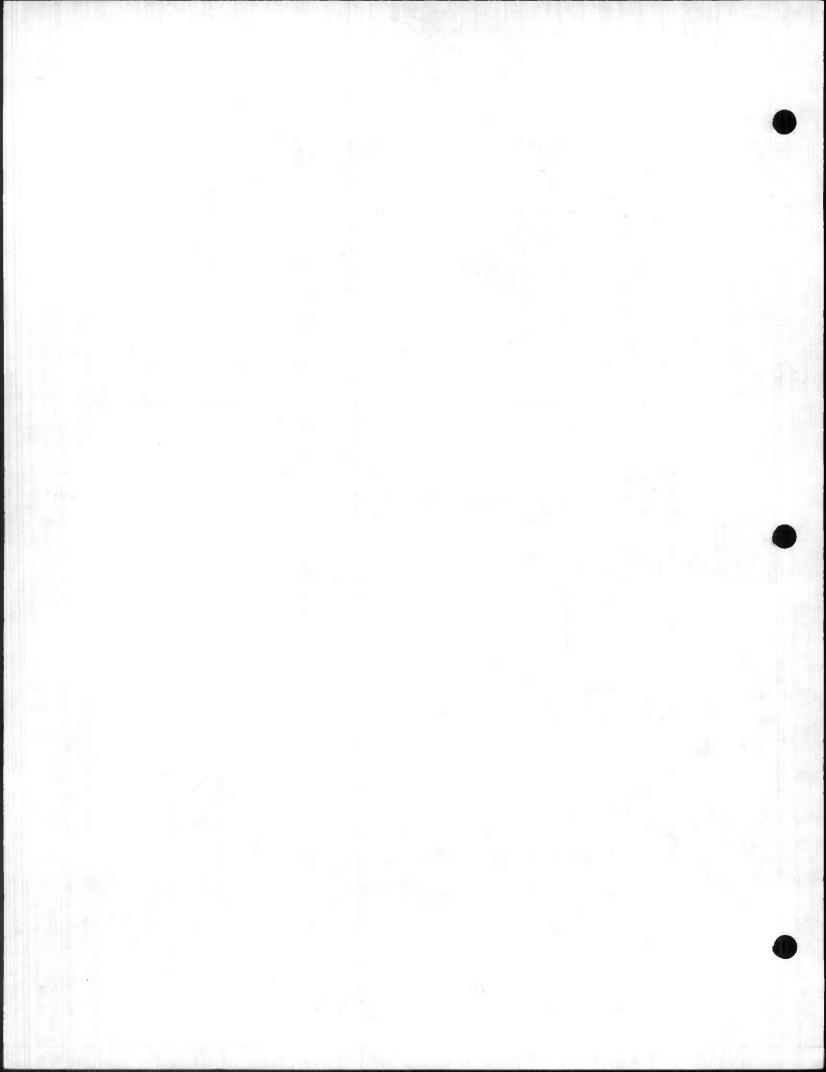
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner steted. 29b. Signature and title of certifie 29c. License number

2000

29d. Dete signed (Month, Dey, Year) 11, 2000

30. Name and address of person eted cause of death (Item 23a) (Type, Print) 10m45

Gesen 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:15 A.M. **Physician** Fredrick B. Wildberger Sr. February 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Franklin Square Hospital Center Kosadak Baltimore If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 218 09 1768 12 M 2□ F Yrs. 79 Director June 22, 1920 Maryland Usual Residence of Decedent the Meryland permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or frama 23s or 28s-1 show any Injury or other traumatic evant, the Medical Examiner must be notified at ence. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10e Street and Number 10f Zip Code 10g, Citizen of What Country? 809 Woodlynn Rd. 21221 USA Funeral 14. Reca - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No WW II If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White þ ILD REGER, Fraderick 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Fuel Oil Co. 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk. Beatrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel G. Wildberger (Son) 312 West Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Elkridge, Md. Meadowridge Mem. Park 2/15/2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name end Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. OKM Per 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, sheck, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** ARCTION /Medical Immediate Cause (Final MOLL disease or condition resulting in deeth) Examiner Examiner The law requires that the deeth certificets be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): USB 85 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Obstructive pulmonary disease þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: funeral director, 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affar 1 Netural 2 Accident 5 Pending investigation ne Hospital or Attending n 24 hours after death. ne Funeral Director: Afte 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 9 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 052379 February 12, 2000 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 1124 Maca avenue Savitha. Shivananda Baltimore, Maryland 21221

DHMH 16 Rev 6/95

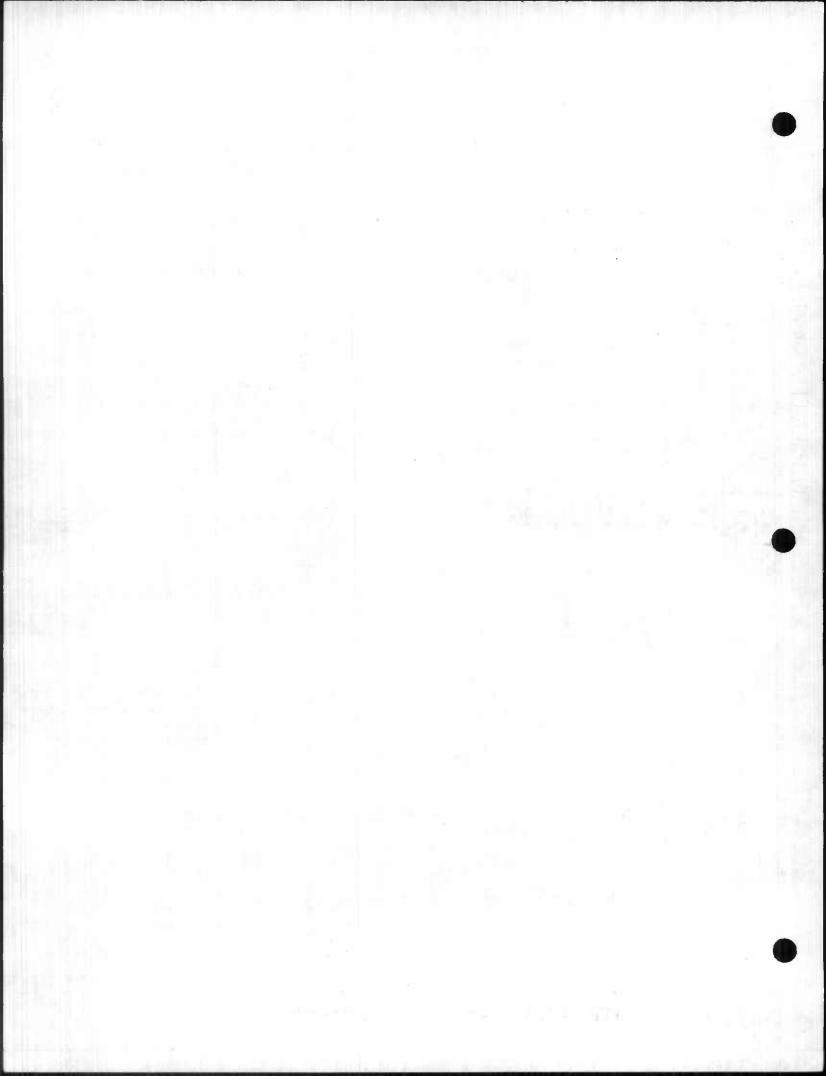
State

Registrar

31. Date liled (Month, Day, Year)

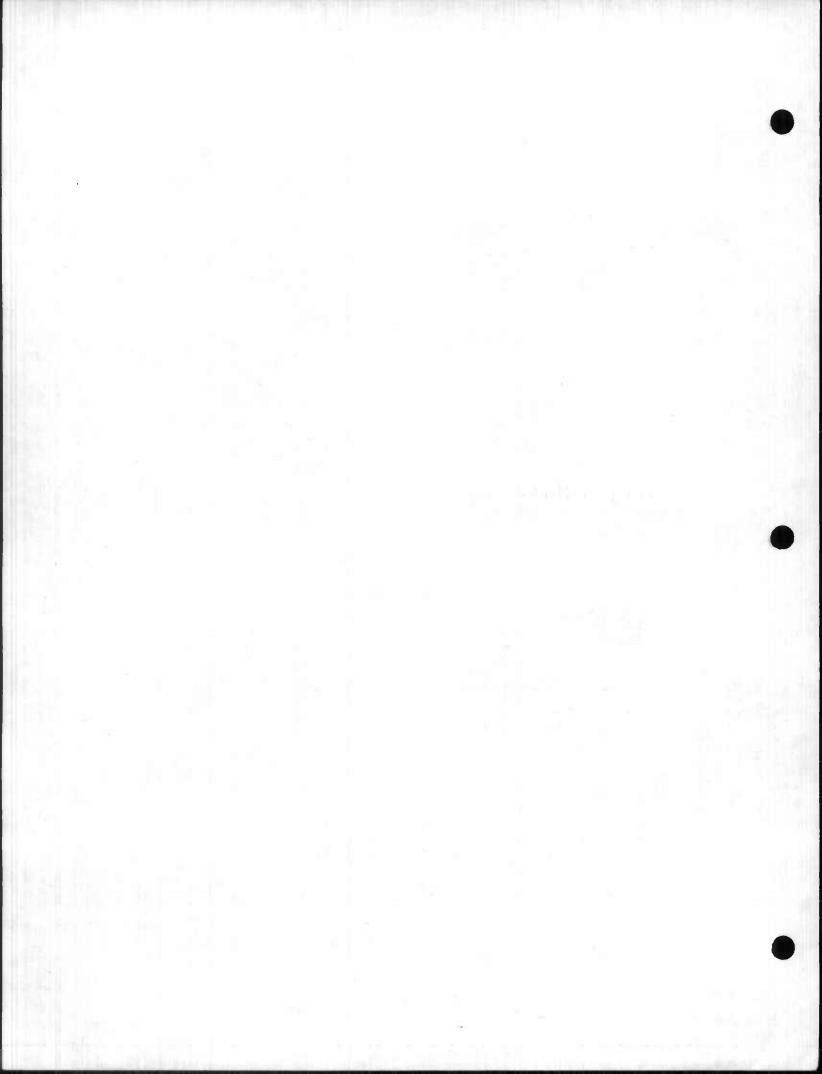
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32. Regist/ar's Signeture

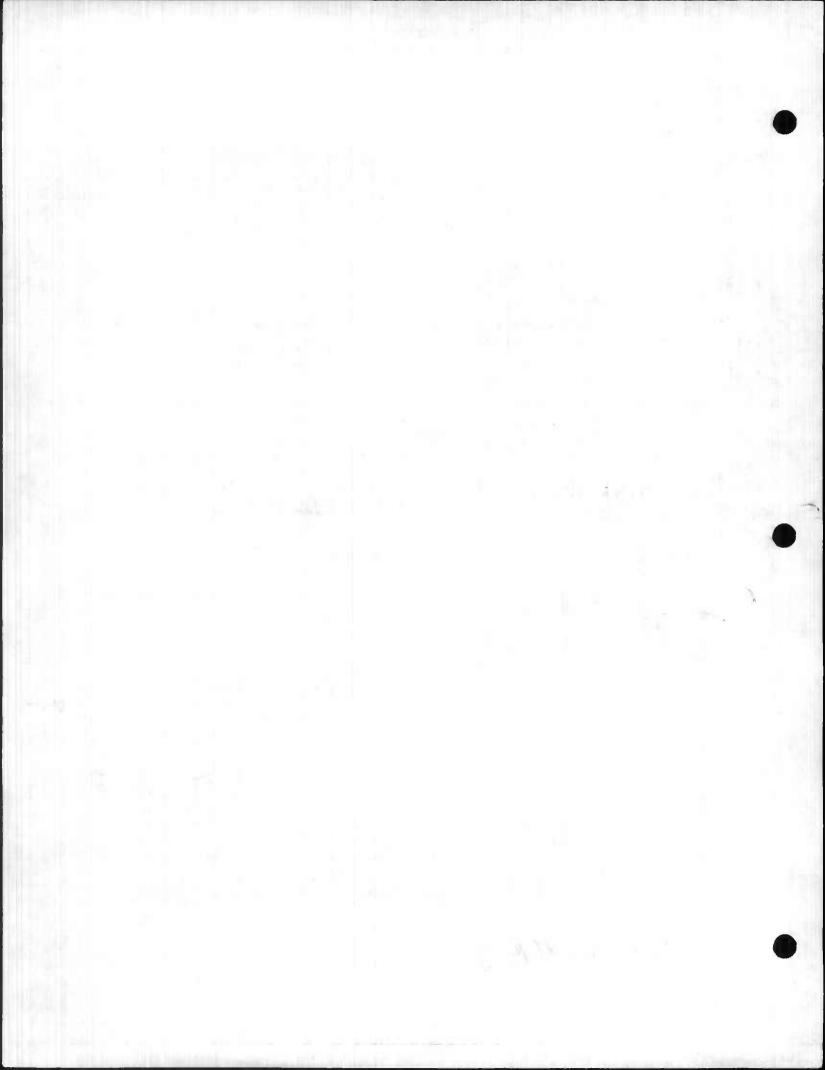


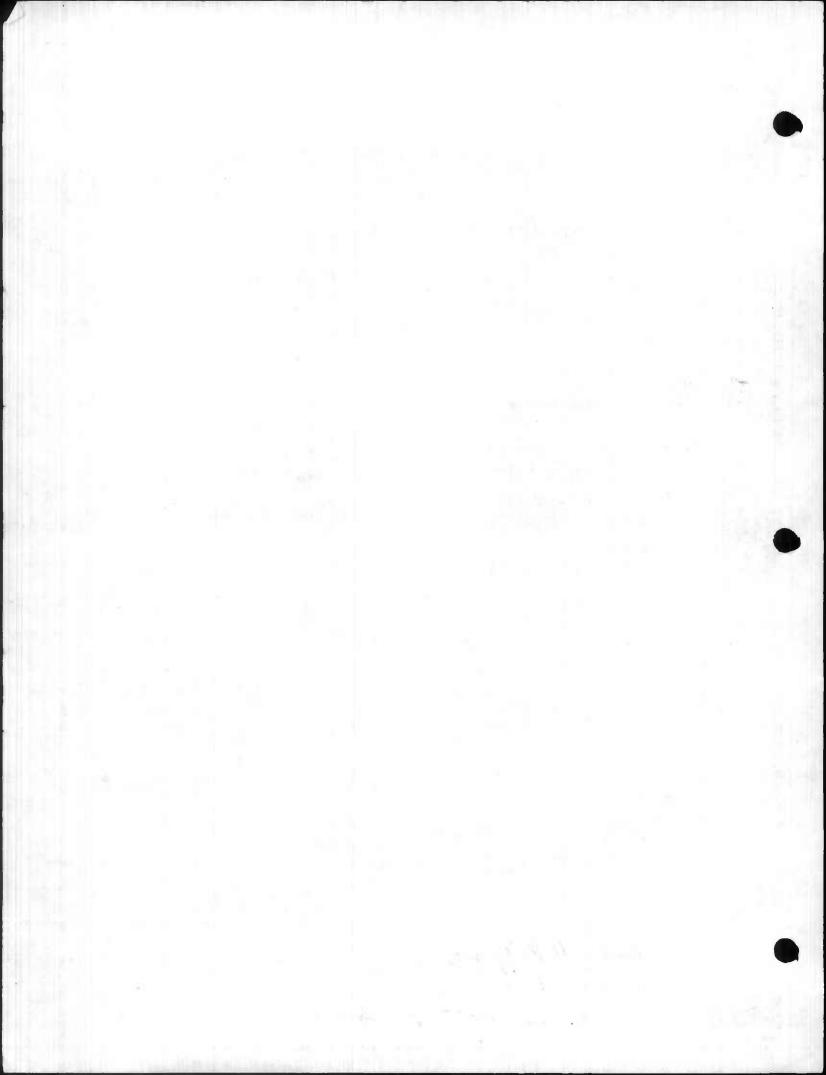
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 3 8 1

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|--|-------------------------|---|-------------------------------|--|---|--------------------------|-------------|------------------------|-------------------|---|-------------------------------|------------------------------|--|-----------|
| | 1. Decede | ent's Nama (Fi | rst, Middla, La | st) | | | | | | 2. Date of De | eath Day | Year | 3. Time of | Death |
| hysician /Medical | | HARF | RY E. W | EHNER. II | Т | | | | | FEB | | 000 | 4:30 | Р |
| Examiner | 4a Facilit | | | e street and numbe | | | | | 4b. City, Town, o | r Location of Deat | | | 7.1.00 | - |
| | | HOWARD | COUNTY | GENERAL | HOSPI | TAL | | | COLUME | BIA | HOW | ARD | | |
| neral | 5. Social | Security Numb | ar 6. S | ex 7. | | last birthday) | If Unde | r 1 Year Days | | rs. 8. Date of Bi | rth | | ace (State o | or Foreig |
| ector | 21 | 7-40-72 | 259 | M 2DF | 56 | Yrs. | William | Days | 110010 | MAY 9, | 1943 | | land | |
| | | sidance of Dec | | | | | | | | | | | | |
| Example must be notified at by Funeral Director | 10a. State | | o. County | | | y, Town or Lo | | | | | | 10 | 0d. Inside C | |
| cto | M | U F | loward | | FT | licott | | | | | | | 1 🗆 Yes | XIN |
| Dire | | et and Number | | | | | 1 | p Coda | | | 10g. Citizen of | | try? | |
| la la | 510 | 1 Cryst | al Spr | ings Dr. | | | 2 | 2104 | 3 | | US | P | | |
| Funeral Director | 11. Marila | al Status evar Married | 2/YMarried | 12. Was Decedar Armed Forca | s? | | | | | (Specify Yes or No arto Rican, atc.) | Bia | ce - America ck, Whita, a | HC. | |
| þ | 3 🗆 W | Vidowed 4 □ | | 1 [X] Yes 2 [If Yes, Giva Year or Data: | s: | 1 | I □ Yas | 2X No | Specify: | | Specif | y: Whit | ce | |
| Completed by | | | Decedant's Ed | | | 16a. Deced | lant's Usu | al Occup | oation | | 16b. Kind of B | usinass/Ind | lustry | |
| ple | Flomer | (Specify o | nly highest gra | da completed) College (1-4c | | (Giva | kind of wo | ork dona Ise ratire | during most of w | rorking | | | | |
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| BeC | 17. Fatha | | , Middla, Last) | | | | | | 7 | ama (First, Middle | | | 0010 | |
| To B | Ha: | rry Edw | ard Wel | hner, Jr. | | | | | Margare | t Klem | | | | |
| - | 19a. Inlor | rmant's Name/ | Ralationship (| Type, Print) | | 19b. Mailin | o Addras | a (Street | | Rural Routa Numb | er. City or Town | State, Zip | Code) | |
| | | | ner - 1 | | | | | | | Dr., Ell | | | | 043 |
| | | od ol Dispositi | | | 20b. P | lace of Dispo | sition (Na | ma of | | D-1- | | | | .043 |
| once. To Be Comp | | | | Ramoval from Sta | | ematary, cran n Havei | | | | 2/12/00 | | | | |
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| | | 1018 | 1. IVIC | usear | 1 | 725 | 0 Wa | shin | aton Bly | vd., Elki | nidoe M | d 5 | 1075 | TIII |
| | 23a. Part | t1. Entar tha di ck, or heert lail | saasa, or compute a List only | plicationa that caus | ed the death | h. Do not enta | ar tha mo | da of dyi | ng, such as card | iac or raspiratory a | rrast, | | Approximat Intarval Bet | |
| an | | | | | | | | | | | | | Onset and | Death |
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| P | rasulting | in death) Last | | | | | | | | | | i | | |
| Physician/M | | | | d | | | | | | | | | | |
| 50 | Part II. Oti | her significant | conditions co | ontributing to deeth | but not rasi | ulting in the un | ndarlvino | causa oi | ven in Part I | 23b. Did | tobacco use co | entribute to | the cause | of death |
| thys | | | | | | | ,,,,,, | and g | | | Yes 2□ No | ∂ Prob | | Unknow |
| ру Р | ACU | IE KENA | L FAIL | UKE | | | | | | _ | | XX | | |
| 8 | 2011 | to live | r fail | uro | | | | | | 24a. Was | an autopsy | | re autopsy | |
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| Be | axami | | 2000 | Hospital: | | | | Ott | her: | eath (Check only | | | | |
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| - 6 | 1 XXV | ar of Death aturat 5 | Panding | | Day Year) | 28b. Tima ol Injury | | 28c. Inju Wo | | 28d. Dascribe | how Injury occu | rred | | |
| Certification: | 2□A 3□S | ccidant | investigation Could not be | | | | М | | Yas 2 No | | | | | |
| 틛 | | lomicida | datarmined | 286. Place of I | Injury - At ho atc. <i>(Specif</i>) | oma, farm, stra /) | aat, lactor | y, office | | 281. Location (| (Street and Num wn, Stata) | ber or Rura | Routa Nun | ıber, |
| రి | | | | | | | | | | | | | | |
| edical | 29a. Carti | ifiar XX | Certifying Phy | yalcian: To the bes | of avaminat | wiedga, daath | occurred | at tha ti | ma, data and pla | ce, and dua to the | causa(s) and m | annar as at | ated. | (2 |
| | one | | | and mannar | statad. | | donganor | ., , . | philion, dudin oo | Sorros at the time, | data aria piace, | and doc to | | , |
| 2/ | 29b. Signi | ature and title | of certifier | 11 | - | | 29 | | sa number | | 29d. Data signe | | | |
| / | 1 | / Which | 5/20 | 114 | | two | | D4 | 1274 | | FEB 0 | 9, 20 | 00 | |
| VI | 30. Nama | and addrass of | f person who d | complated causa of | death (Item | 23a) (Type. I | Print) | | | | | | | |
| M | | | | AN, M.D. | | | | TIIVE | NT DADET | IAY COT IN | IRTA MD | 210// | | |
| State | | iled (Month, Di | | | strar's Migna | | /. | - 0211 | / IANK | ILLI GOLIUP | DIA FID | 21044 | | |
| State | 31. Data I | ileo (Monto, Di | FFR 1 | 4 2 MAN | strar s angha | was | 19 | A. | souls! | | | | | |



| 00-0761-510 jhm DAVID amend | liten 239,27 | .28a.b.c.c | Type or State of | Print in I | nd / Depa | artment | of H | lealth a | and Me | | | gible. | 143 | 85 |
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| WADDEN per II | ne G781 3/8/0 | yg . | | | Cel | tificate | e or i | Death | | 2. Date of De | Reg. No. | | | e of Death |
| Physician | 100000000000000000000000000000000000000 | | | | | | | | | Month | Dey | Yeer | | |
| /Medical Examiner | 4e Facility Neme (If | Eugene W | e street and nu | mber) | | | - | tb. City, To | | FEBRUA ation of Deat | | 2000 nty of Death | 119: | 50 PM |
| LAdillilei | ST. AGNI | | | | | | | BALTI | IMORE | | N, | A | | |
| Funeral | 5. Social Security Nu | | Sex 1)∑M 2□F | 7. Age (In yrs. | | If Under | 1 Year Days | If Under Hours | 24 Hrs. Min. | B. Date of Bi (Month, D | rth lay, Year) | 9. Birth | place (Sta | le or Foreign |
| Director | 213.82.69 Usual Residence of E | 910 | W 501 | 39 | Yrs. | | | | | 12. 19 | 1960 | | land | |
| pue/ | | 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | | | | 10d. Inside | e City Limits |
| Men al at at at at at at at at at at at at at | MD | N/A | | В | altimo | re | | | | | | | XUY | res 2□No |
| vith the Merylen or 28e-f show he notified at Director | 10e. Street and Num | ber | | | | 10f. Zip | Code | | | | 10g. Citizen o | of What Cou | intry? | |
| eth w | 333 Fur | row St. | | | | | 1223 | | | | US | A ace - Amer | | |
| eter death v or forms 23e infrar must | 11. Merital Status | d 2 Married | Armed F | | I,S. 13. \ | Wes Decede f Yes, speci | ent of Hi ify Cuba | lispanic Ori an, Mexicar | igin? (Spec n, Puerto R | ity Yes or Neican, etc.) | | ace - Amer leck, Whita | | 4 |
| D20 urs eth | 1)(C) Never Merrie 3 ☐ Widowed 4 | | 1 Yes If Yes, Gi Yeer or D | ve^\ | | 1□ Yes a | (1 No | Specify: | 24 | | Spec | ily: Whi | te | |
| 5-0 72 ho | | 15. Decedent's E | | | 16a. Deced | dent's Usuel | Occup | ation | t of workin | 0 | 16b. Kind of Business/Indus | | | |
| To de la la la la la la la la la la la la la | Elementary/Secon | | College (| | - 75 | e kind of work done during most of DO NOT use retired) | | | | | | | | |
| Co. Co. | 10 17. Father's Name (F | iret Middle Lee | 2) | | Sh | eet Ro | ock | | | (Einet Middle | Cons | truct | ion | |
| d ber de de de de de de de de de de de de de | | . Warren | | | | | | | | (Smith | | ame/ | | |
| ahoun ahoun mark | 19a. Informant's Ner | ne/Reletionship | (Type, Print) | | 19b. Mailir | ng Address | (Street | | | | ber, City or Tox | vn, State, Zi | p Code) | |
| Mand 2 and 2 aith a 27 is | Nancy Llo | oyd/_Mot | her | | 333 | Furrov | v St | . Bal | Ltimoı | ce. MD | 21223 | | | |
| Baltimore, Maryland 21215-00 mand mary be filled within 72 hos permit. Pages 1 and 2 should be filled within 72 hos permit in from 72 in marked other than "natural institution in programs in filled marked other than "natural institution in the filled other than "natural institution in the filled other than "natural institution in the filled other than "natural institution of the filled | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State | | | | | | | | | |) | | | |
| Pag ment amt: h | 4 Donetion | | | Ba | ltimor | e Wash | ning | . Cre | em. 02 | 2/1320 | 00 Lau | rel, | MD | |
| Sail emit separt ny inj | 21. Signeture of Fun | erel Service Lice | nsee | . 1 | | . Nama and | | | | Llomo | a Mana | l Dád | M- | D |
| 20300 | 1118 | a . MIC | una | | In | 725 | 50 W | lashin | ngton | Blvd. | @ Meac Elkric | lge, M | ge Me d 210 | m. Par 175 |
| | 23a. Part1. Enter the shock, or heart | disease, or con feilure. List only | plications that one cause on o | caused the deel sech line. | th. Do not ent | er the mode | of dyin | ng, such as | cardiac or | respiratory | errest, | 1 | | mete Between nd Death |
| | Immediate Cause (F | inal | - | | | | | | | | | | | |
| Examiner | disease or condition resulting in death) | | a. <u>Er</u> | DOCARDIT | IS COMPL or as a consec | | BY | MPOIHE | RMIA | | | 1 | | |
| D = C | | | | 00010(| or as a conseq | judinos dij. | | | | | | | | |
| acute and trans | Sequentially tist cond | ditions, | b | Due to (d | or as a conseq | uence of): | | | | | | 1 | | |
| | if any, leading to immoduse. Enter Underli Cause (Disease or in | | c | | | | | | | | | 1 | | |
| Box 6876(eth certificate be titending physicia for use as the built ilan/Medical | that initiated events resulting in death) La | | | Due to (d | or as a conseq | uence of): | | | | | | - ! | | |
| Box 6 | | | d | | | | | | | | , | - ! | | |
| . p . p | Part II. Other signific | ant conditions | contributing to d | eath hut not res | sulting in the u | nderlying ca | use niv | en in Part I | | 23h Did | I tobacco usa | contribute | to the cau | se of death? |
| P.O d by the seteche | | ant obnational | onthibuting to d | outil but not ros | oning in the di | noony mg ou | oso giv | | | | Yaa 2□ No | | | Baknown |
| igned be de by P | | | | | | | | | | | II HAM | | | V . |
| A Record The lew requirements to the lew requirements to the page 2 should Completed | | | | | | | | | | | s en autopsy formed? | 0 | Vere autop vailable prompletion | |
| Reco | | | | | | | | | | | | 0 | f death? | oi cause |
| Vital Re- iclan: The lev certificate has rector, page 2 | | | | | | | | | | 1/5 | Yes 2□No | 1 | BYes : | 2□ No |
| of Vital In Physician: The Physician: The certificate and director, page To Be Co | 25. Was case referre examiner? 1 ☑ Yes 2 ☐ N | | Hospitel: | | (FD)0 | | Oth | or | | (Check only | | Dub (C | 14.3 | |
| Olvision of Vital Records, or Attending Physician: The law requires the death. Director: After this certificate has been signed in by the tuneral director, page 2 should be ertification: To Be Completed by | 27. Manner of Death | 0 | | Inpatient 2 of Injury th, Day Year) | ER/Outpatien 28b. Time of | | 3c. Injur Wor | 4 🗆 140 | 2 | Bd. Describe | how injury occ | | - | exposed |
| Attending Indeption of the fune fune fune fune fune fune full filtration | 1 ☐ Netural 2 ☐ Accident | 5 Pending investigation | | | 4:19 | М | | Yes 2 🗓 | No | to cold | 1 | | Jac . | 24mm |
| Division C na ther death. na birector: After the ied in by the tunera Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | | of Injury - At hing, etc. (Specif | ome, ferm, str | eet, factory, | office | | | City or To | (Street and Nu | mber or Ru 14 S. I | Route I | Vumber, |
| DIVISION To the Hospital or Attention 24 hours after deat for the Eureral Director: completely filled in by the Medical Certifical | | | resid | | | | | | | altimor | e, Md. | T- D+ 1 | Luce i | - Leet |
| To the Hospital of Within 24 hours at To the Funeral Decembers (Hilled I | | ☐ Certifying Pt | miner: On the b | asis of examine | | | | | | | | | | se(s) |
| Signal S | 29b. Signatura and ti | tle of certifier | eno men | ner steted. | | 29c. | Licens | e number | | | 29d. Date sig | ned (Month | , Day, Yea | ir) |
| F 3 F 8 | 11 | 0 | 11/15 | 0 | | | OCM | | | | FEBRU | | | |
| 1110 | 30. Name and address | is of person who | completed caus | sero deeth (tter | m 23a) (Type, | Print) | | | | | | | | |
| /// | | DONE / | u.ki | 6 | | | tre | et, B | a).tim | ore, M | Marylan | d 212 | 01. | |
| State | 31. Date filed (Month | | | egistrer's Signe | eture | 1 | | | | | 0.7 | | | |
| Registrar | rE | B 1 4 20 | 00 0 | Epson | F. | 100 | Me. | | | | | | | |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\mathbb U$ Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 10, 2000 Stella FEBRUARY 32 telkoski 4b. City, Town, or Location of Death County of Death 4a Facility Nama (If not institution, giva street and number) HOSPITAL BALTIMORE MERCY H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months Days 1□ M 20 F 83 Yrs. 216-07-0308 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 1007 FAWN ST. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Naver Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Provorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA OWN HOME 10 tome maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) RALPH ONCETTA SPARENZELLA PETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2928 CRAIGSTON ABINGDON MD 21009 KOBERT ZELKOSKI (SON LANC 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 12 Burial 2 Cramation 3 Ramoval from State 1/14/00 4 ☐ Donation 5 ☐ Other (Specify) toly REDEEMER CEN BALTIMORE 22. Nama and Address of Facility SONS FUNEROL HOME 4 322 S. HiGH ST. BUTO, Md. in, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximete Interval Between Onset and Death ongestive heart Immediate Cause (Final disaasa or condition resulting in death) ORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? CArdioVAScular disasse 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? osteo Arthotis 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier "Inld aus

certificete be Division of Vital Records, i or Attend after death Director: /

Physician /Medical

Examiner

Director

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Completed

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of 2 should be filed within 72 hours after death with the Menylen Ih and Mentel hygiene.

7 Is marked other than "netural", or itema 23a or 28a-f show traumatic event, its Medical Examine must be notified as

permit. Pages 1 and 2 st Depertment of Heelth and Important: If Item 27 is n any Injury or other traun once.

Physician

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Certification:

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Baltimore, Maryland 21215-0020

To the Hospital within 24 hours a To the Funeral C Hospital

death.

Registrar

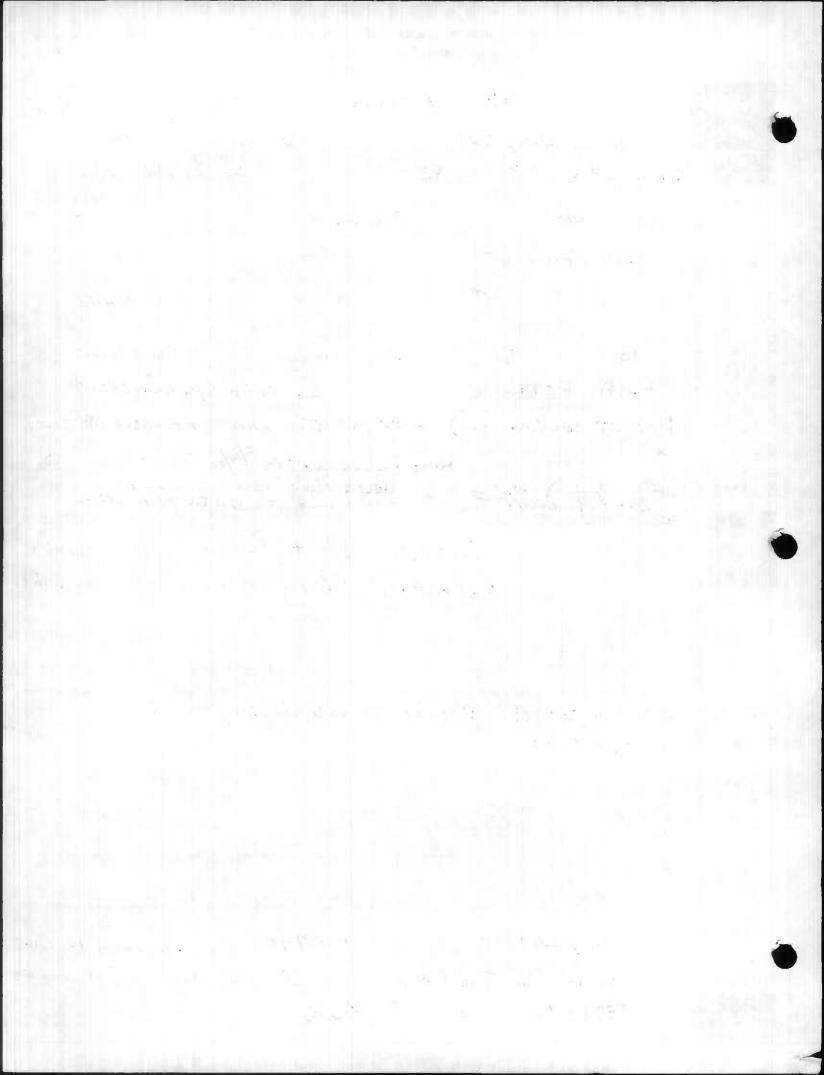
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Nevns W Todd M.D. Nenus 31. Date filed (Month, Day, Year) FEB 1 4 2000

32. Registrer's Signature

St Paul Place

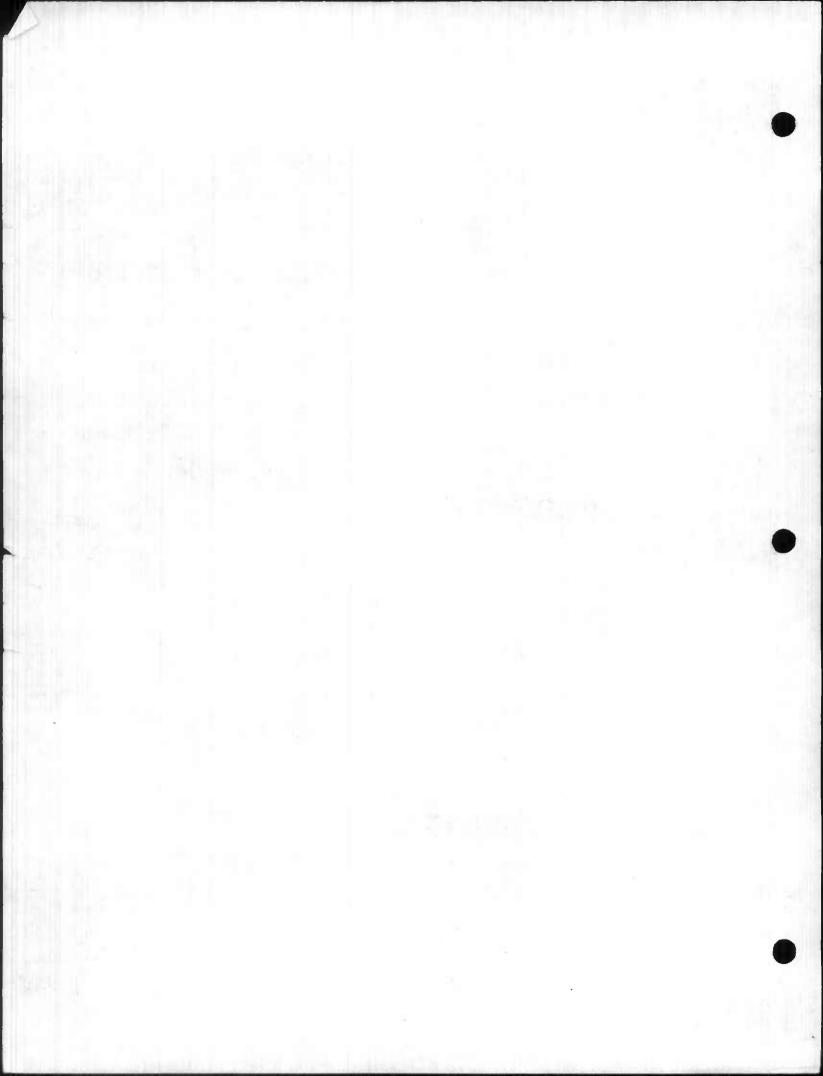
Baltimere MA



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Des **Physician** JOSEPH AKENS 9,2000 Feb. a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 S. DUNCAN STREET BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 220-20-5488 Yrs NOV MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits XX Yes 2 No Director 28a-f MD. N/A BALTIMORE 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code her must be ъ 508 S. DUNCAN STREET U.S.A. 21231 Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

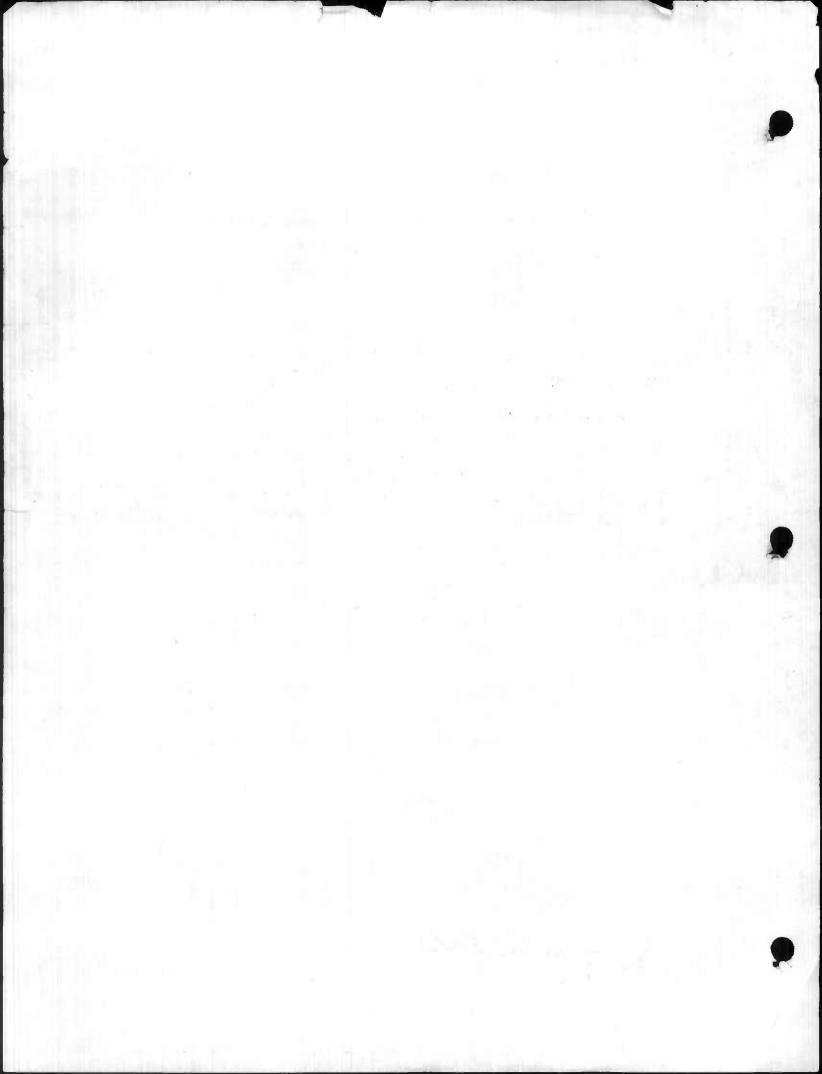
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married "natural", or I Baltimore, Maryland 21215-0020 1 ☐ Yes 次 (No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglers. Important: it lean 27 is marked other tran "na any injury or other traumatic event, the Medic 2008. Elementary/Secondary (0-12) College (1-4or 5+) 8 MACHINIST AMERICAN NATIONAL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN ZAKENS MARY MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 S. DUNCAN STREET, BALTIMORE, MARYLAND 21231 THERESA ZAKENS/ WIFE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CEMETERY 2/11/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MARYLAND 21231 23a. Part1. Enter the disease, or complications that caused the death. Do-not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SUS /Medical Immediate Cause (Final disease or condition resulting in death) ar Examiner Due to (or as a consequence of): Examiner 2 physician and the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): . for use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? No 1 Yes 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 certificate hes No 1 Yes 1 ☐ Yes Ve No or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only onle) Hospital: Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 1 | Yes 2 | Ao 1 Inpatient 2 ER/Outpatient 3 DOA this Inneral 28d. Describe how injury occurred 27. Manner of De 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Definient 1∏ Yes 2 No 24 hours effer death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and little of certified 29d. Dale signed (Month, Day, Year) 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) HUDSONST SUITE C BALTO MD 2004 ENIS W. MAG Mayay 2801 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State FER 1 4 2000 Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 04389 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27,2000 WILLIAM REED ADDIS, SR. JANUARY 9:42P. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George's Laurel 8. Date of Birth (Month, Day, Year) July 31, 1943 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F Days Hours 034-32-8671 56 Pennsylvania Director Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be 10804 Howard Terrace 20705 United States Funeral 14. Race - American Indian, Black, White, etc. Hema! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11 Medital Status The Medical Examiner filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 ò 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes 'netural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Capitol Truck 12 Warranty Management Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Heath end Zehould be fill Heath end Mental H Iem 27 la marked oth Be Howard K. Addis Lewis 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) out if item 27 is a Joyce Anne Addis (wife) same as #10 Baltimore 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition Pages nant of H Burlel 2 Cremetion 3 Removel from Stete Fort Lincoln Cemetery 2/1/2000 Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or obmplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Myocardial infarction disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine Diabetes The law requires that the deeth certificate be executed as the buriel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Hypertension Box 68760. physicien Physician/Medical Due to (or es a consequence of): for use signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Dunknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? page 2 hes 1 ☐ Yes XXNo 1 ☐ Yes 2 No certificate of Vital Physician: 25. Wes casa referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 XX R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes **₹**CXNo this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending Division 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner atleted. Medical 29e. Certifier completely (Check only one) the 200. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Wille Come D28267 January 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Voss, M.D. 11402 Allview Drive Beltsville, Maryland 20705 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State JAN 31 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

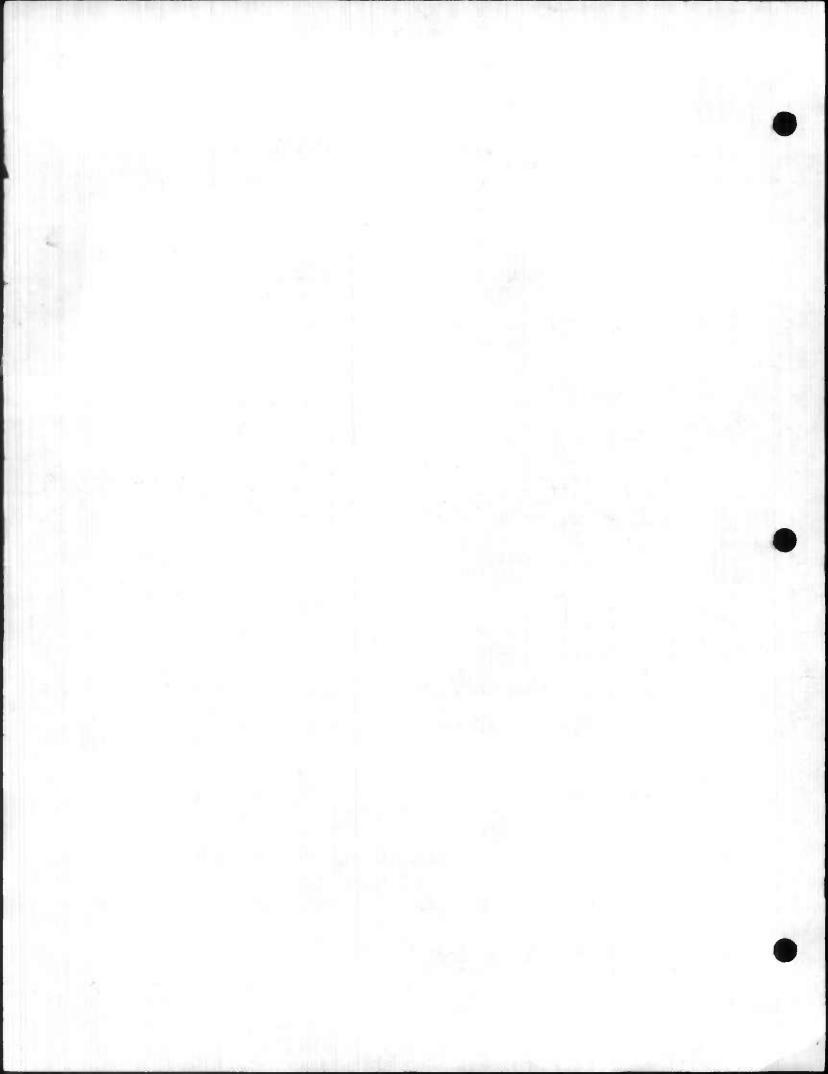
Reg. No.

2. Dete of Death

3. Time of Death

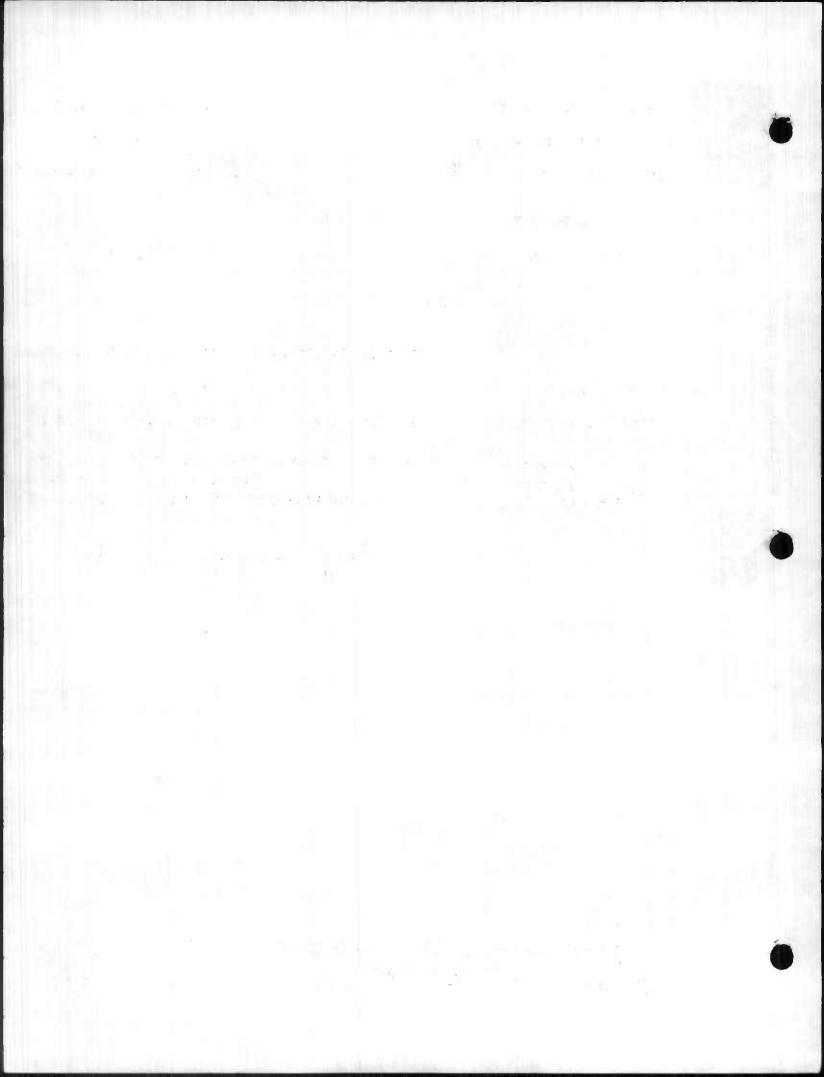
3. Time of Death

| | | | | Certificate | of Death | | Re | g. No. | | 14330 |
|-------------------------|---|---|--------------------------|-------------------------------------|----------------------|---------------|---------------------------|--|-------------|--------------------------------------|
| D I. 102.11 | 1. Decedent's Name (First, Mid | dle, Last) | | | | | 2. Dete of Deatl Month | | Year | 3. Tima of Death |
| Physician /Medical | Pedro R. Arms | strong-Schu | ick | | | | January | 28, 20 | | 5:12 PM |
| Examiner | 4a Facility Name (If not instituti | ion, give street and nun | iber) | | 4b. City, To | | ation of Death | ste of Death onth Day Year nuary 28, 2000 of Death 4c. County of Deat Montgomer ate of Birth Ionth, Dey, Year) Tuary 14, 1914 Pue 10g. Citizen of Whet Country 14, 1914 Pue 11. Race - American Bleck, White Research Separate Pue 12. Company Monte Pue 13. Middle, Maiden Surmame) 14. Nace - American Pue 15. Company Monte Pue 16. City or Town, State, American Pue 16. A. Pumphrey Func. 7557 Wisc 17. Pumphrey Func. 7557 Wisc 18. A. Pumphrey Func. 7557 Wisc 19. Bethesda, 19. Pue 20g. Location City or Town, State, 20. Pue 21. Pue 21 No 30 Pue 22. No 30 Pue 23. Besidence 8 Other (Spe 24b. Pue 24b. Pue 25c Residence 8 Other (Spe 26c Residence 8 Other (Spe 26c Residence 8 Other (Spe 27c Pue 28c Pue 29c Residence 8 Other (Spe 29c Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Location City or Town, State, 20. Pue 29c Pue 20c Pu | | |
| | Suburban Hosp | ital | | | Bethe | sda | | Montg | omery | У |
| Funeral | 5. Social Security Number | | 7. Age (In yrs. last bir | rthday) If Under 1 | | 24 Hrs. | 8. Date of Birth | W1 | 9. Birth | plece (State or Foreign ntry) |
| Director | 580-24-1072 | 12 M 2□ F | 85 | Yrs. Months I | Days Hours | | | Reg. No. of Death Day Year ary 28, 2000 Death 4c. County of Death h, Dey, Year) Pary 14, 1914 10g. Citizen of Whet C United S Or No- Short Specify: White Can Specify: White Company Company Iddle, Maiden Surname) Uck Jumber, City or Town, State, r Spring, MD 20c. Location - City or Bethesda, A. Pumphrey F nc. 7557 Wisc 0814-3501 ory errest, Did tobecco usa contribut 1 Yea 2 No 3 T Wes an autopsy performed? 1 Yes 2 No only one) Residence 8 Other (Sp cribe how injury occurred tion (Street and Number or F or Town, Stete) | | |
| | Usual Residence of Decedent | | - 05 | | | 1-1-1-1 | cordary | Death Day Year ary 28, 2000 Starty 29, Birthplec Country, ary 14, 1914 Puerto State of No. 14, Race - American Bleck, White, etc. 16b. Kind of Business/Indus Home Improve Company State, City or Town, State, Zip Company Starty 20c. Location City or Town Bethesda, Mar A. Pumphrey Functions 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town State, Zip Company Starty 20c. Location City or Town St | CO RICO | |
| 5 w | 10a. State 10b. Count | ly | 10c. City, Tow | n or Location | | | | | | 10d. Inside City Limits |
| Ashor Sed at | Puerto | | Bauen | Gardens, | San Ins | n | | | 3 | 1X Yes 2 No |
| be notified Director | Rico - | | Dquen | 10f. Zip C | | 411 | 10 | og. Citizen of \ | What Cou | ntry? |
| | QQ1 Julio Rue | das St. | | 009 | 26 | | | Unite | d St | ates |
| 2 | 11. Merital Status | | dent Ever in U,S. | 13. Wes Deceder | | igin? (Spec | afv Yes or No- | | | |
| Funeral | 1 ☐ Never Merried 2 ☐ Ma | Armed For | ces? | If Yes, specify | Cuban, Mexicar | n, Puerto R | ican, etc.) | 210 | ck, White, | , etc. |
| by i | | M Yes Give | 9 | 1 ☑ Yes 2 □ | No Specify: | Puert | to Rica | 1 Specify | . Whi | .te |
| | | ent's Education | | . Decedent's Usual (| Occupation | | | 16b. Kind of B | usiness/in | ndustry |
| tel | (Specify only high | est grade completed) | | (Give kind of work life. DO NOT use | done during mos | it of working | 9 | | | |
| Completed | Elementary/Secondary (0-12) | College (1- | | Proprieto | | | | | - | Velilerre |
| Ö | 17. Father's Neme (First, Middle | | | | | er's Neme | (First, Middle, N | | - | |
| 88 | - 1 - 1 | | | | Conc | chita | Schuck | | | |
| 2 | 19a. Informant's Neme/Relation | | 100 | Mailing Address / | | | | City or Town | State 7ii | n Code) |
| | | | | | | | | | | |
| | Mercedes Armst: | rong/ Daugh | ter 20b Place 0 | 00 Tellur f Disposition (Name | ide Plac | ce, S: | ilver Si | oring, | MD 2 | 0906 |
| | 1 ☐ Burial 2 ☑ Cremation | 3 Removel from S | comoto | ry, crematory or other | er place) | Fe | b. 1, | EGG. EGGGHON | Only of the | J, 0.0.0 |
| | 4 Donation 5 Other | (Specify) | Montgon | nery Cremato | | | | | | |
| ģ | 21. Signature of Funeral Service | 6 icensee | | 22. Neme and | Address of Fecili | Nobe | ert A. | Pumphre | y Fu | neral Home |
| a | Many | Ishar 1 | M00689 | | | | | | ISCO | usin Ave., |
| | 23a. Part1. firmer the disease, | or complications that ca st only one cause on ea | used the death. Do | not enter the mode of | of dying, such es | cardiec or | respiretory erre | ist, | 1 | Approximate Interval Between |
| ian | - Commission En | at only one cause on et | out wife. | | | | | | 1 | Onset and Deeth |
| cal | Immediete Causa (Finel disease or condition | Conti | c Shock | | | | | | : | 2 days |
| er | resulting in death) | a. Septi | | consequence of): | | | | | 1 | 2 days |
| 1 | | | 200 10 (01 23 2 | consequence ory. | | | | | i | |
| edicai Examiner | Commentially list conditions | b | Due to for as a | consequence of): | | | | | 1 | |
| EX. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events | | | as in a square of the | | | | | 1 | |
| Cai | Cause (Diseese or injury that initiated events | C | Due to for as a | consequence of): | | | | | + | |
| P | resulting in death) Last | | Doe to (or as a f | consequence or). | | | | | | |
| . ≥ | | d | | | | | | | | |
| <u>10</u> | | | | | | | | | | |
| Physician | Pert II. Other significant condit | tions contributing to de | ath but not resulting i | n the underlying cau | se given in Pert | 1. | | | | |
| 4 | Lymphoma | | | | | | 1 O Ye | a 2 No | 3 Pro | bebly 4 1 Unknown |
| by | | | | | | | 24a Was - | n autoner: | 24h W | Vare eutopsy findings |
| Completed | | | | | | | perform | ned? | S | vsilable prior to ompletion of cause |
| ģ | | | | | | | | | O | f death? |
| ő | | | | | | | 1□ Ye | s 2 No | 1 | Yes 2 No |
| Be Com | 25. Wes case reterred to medic examiner? | al | | | 26. Place | e of Deeth | (Check only on | е) | | |
| To | 1 ☐ Yes 2 ☑ No | Hospital: 1 ☑ Ir | patient 2 ER/O | utpatient 3 DOA | Other: 4 N | ursing Hom | e 5 Reside | nce 8 Ott | ner (Speci | ity) |
| | 27. Manner of Death | 28a. Date o | | Time of 28c | : Injury at Work? | 21 | 8d. Describe ho | w injury occur | red | |
| 읦 | 1 Netural 5 Pend 2 Accident inves | itigation | , ouy . ou., | M | 1 Yes 2 | No | | | | |
| <u>S</u> | 3 Suicide 6 Could | mined 286. Place | of Injury - At home, fe | erm, street, fectory, o | office | 21 | 81. Location (St. | reet and Num | ber or Au | ral Route Number, |
| Certification: | 4 Homicide | buildin | g, etc. (Specify) | | | | City of TOWN | i, Siele/ | | |
| 0 | 29a. Certifier 1 → Certify | ing Physician: To the | best of my knowledge | e, death occurred at | the time, date an | nd placa, er | nd due to the ce | suse(s) end m | enner as | ststed. |
| edical | | | sis of examination an | | | | | | | |
| Medica | 29b. Signature and title of certif | | | 29c. t | icense number | | 25 | 9d. Date signe | d (Month | , Day, Year) |
| | 1 1 | Allo. | 1 a DAR | | D38262 | 2 | | | | |
| | nuc | a cell | rely | My)! | D30202 | | Ja | illuary | 30, | 2000 |
| | 30. Name and address of perso | n who completed cause | | | | | | | | |
| | Anurita Mendhi | | | | | ite 34 | 40, Roc | kville. | MD | 20850 |
| State | 31. Dete filed (Month, Day, Yea | | gistrar's Signeture | 4 Ann | els | | | | | |
| Registrar | FEB 0 | % ZUUU / | / | - 1900 | | | | | | |



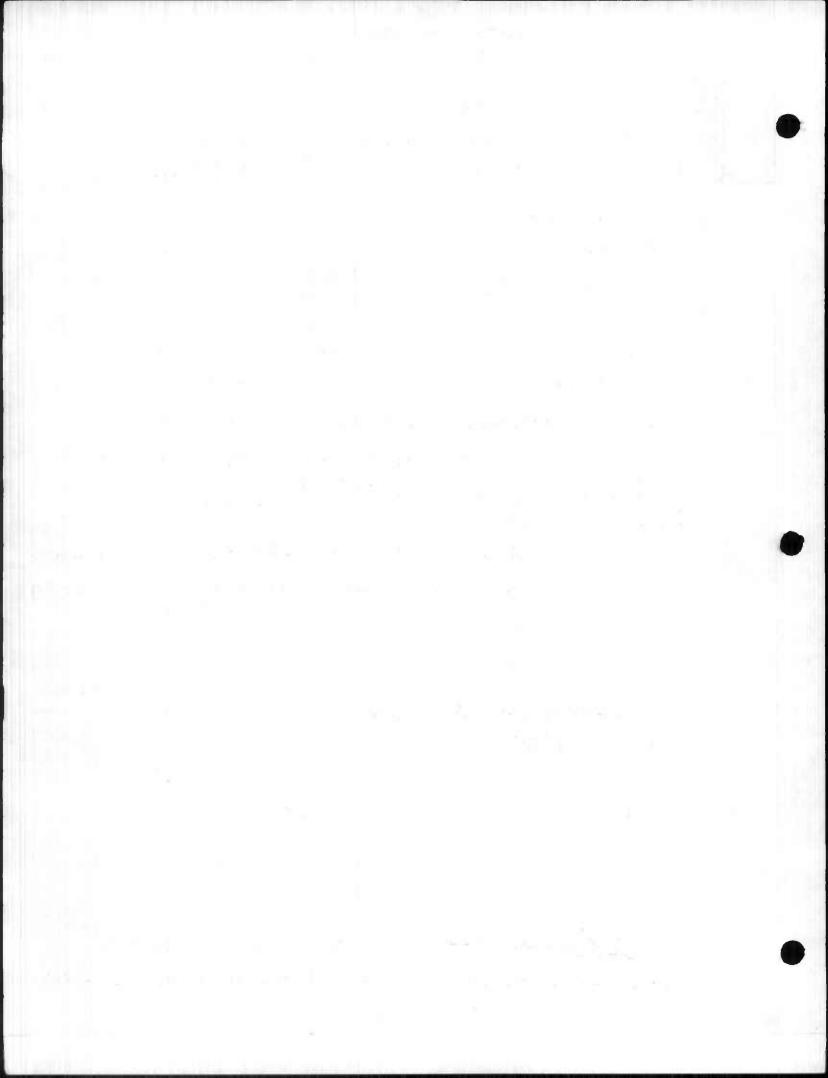
State of Maryland / Department of Health and Mental Hygiena

Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JANUARY 27,2000 **Physician** 4:17 P.M. ROBERT W. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 8. Date of Birth (Month, Day, Year) JUNE 19,1932 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F NORTH CAROLINA Yrs. 67 Director 237-54-2955 Usuel Residence of Decedent with the Marylend r 28a-f ahow 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or addical Examiner must be r UNITED STATES OF AMERICA 20904 213 BEAUMONT ROAD 1 end 2 should be filed within 72 hours efter death v Health and Mental Hygiene. 5m 27 is marked other than "natural", or itema 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 1953–58 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. POSTAL SERVICE CONTRACT TRANSPORTATION SPEC. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked or any Injury or other traumatic every VIOLA WILSON ROBERT ALLEN 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) SILVER SPRING, MARYLAND MARGARET D. ALLEN/SPOUSE 213 BEAUMONT ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriat 2 Cremation 3 Removal from State GATE OF HEAVEN CEMETERY 2/03/2000 4 □ Donation 5 □ Other (Spec SILVER SPRING, MD 21. Signature of Funeral Service Lib 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC SILVER SPRING, MD 20904 11800 NEW HAMPSHIRE AVE. complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Mond Immediate Ceuse (Final disease or condition resulting In death) METONTAT.L /Medical cancinoma Examiner Due to (or as a consequence of): Physician/Medical Examiner physicien and s the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): 80 ettending p 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Probably 4 Unknown signed by ti 1 Yee 2 No þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of ceuse of death? hes 20 No 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) luneral 28d. Describe how injury occurred 27 Manner of Death 28b Time of Certification: 28c. Injury at Work? Netural 5 Pending in 24 hours energible Euneral Director: After Af investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier cartifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F of certifier 29d. Dete signed (Month, Day, Year) 29b. Sig 29c. License number MS 28, G 0005) An von 30. Name and address of poden who completed cause of death (Item 23e) (Type, Print) 18111 72877 KAPIM 7.24 JL NEY mo Da 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State **JAN 31** 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 00

| _ | | | | otate of mary | | Certifica | | | | Reg. No. | | 14392 | |
|----------------------------|---|------------------|---|--|------------------------|--------------------------------------|--|-------------------------------------|--|---|------------------------|--|--|
| п | Physici | ian | Decedent's Name (First, Middle, La | | | | | | 2. Date of D Month | Day | Year | 3. Time 10 th 10:45 FM | |
| | /Medi | | 4a. Fecility Name (If not institution, give | y Lee Applet | ру | | | 4h City Town | Jan. or Location of Dea | 21, 2000 | of Dooth | 10:45 EN | |
| | Examir | ner | Glade Valley Re | A STATE OF THE STA | and N | Jursino | | | | , | | | |
| | Funeral Director | | 5. Social Security Number 6. S | | yrs. last birtl | | 1 Year Days | | | inth Year 1929 | | olece (State or Foreign ntry) | |
| | pu . | | Usual Residence of Decedent 10a. State 10b. County | 10 | c. City, Town | or Location | | | | | т. | Od. Inside City Limits | |
| | f sho | 5 | MD. Freder | | | ldletown | 1 | | | | | 17€ Yes 2 No | |
| | J within 72 hours after death with the Manyland jiene. r than "natural", or Itema 23a or 28a-f show the Madical Examiner must be notified at | Funeral Director | 10e. Street and Number 212 Broad St. | | | | Code 217 | 59 | | 10g. Citizen of What Country? U.S.A. | | | |
| | death | Jera | 11. Marital Status | 12. Wes Decedent Eve | r in U,S. | 13. Was Dece | dent of F | lispanic Origin? | (Specify Yes or N | lo- 14. Race | | can Indian, | |
| 21215-0020 | al', or ite | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes if Yes, specify Cuban, Mexican, Puerto Rican, etc) 1 Yes 2 Mo Specify: | | | | Specify: White | | |
| 5-0 | 72 ho | eted | 15. Decedent's E (Specify only highest gro | ducation ade complated) | 16a. I | Decedent's Usu (Give kind of wo | el Occup | nation during most of v | vorkina | 16b. Kind of Bu | siness/in | dustry | |
| 121 | han vithin | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | | se retire emak | | | OFT | hon | 10 | |
| 6.4 | THE REAL PROPERTY. | Co | 17. Father's Name (First, Middle, Last |) | | HORK | IIIak | | lame (First Middl | e, Meidan Sumam | | ie . | |
| lan | id be ked o ked o | To Be | Carl Lee Keeney | | | | | | e Mae Bea | | | | |
| Maryland | permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other treumatic event, ance. | - | 19a. înformant's Name/Relationship (| Type, Print) | 19b. | Mailing Addras | s (Streat | and Number or | Rural Route Num | ber, City or Town, | State, Zip | Code) | |
| | 1 and 2 Health a em 27 ls | | A. Eugene Appleb | | | | | | letown, l | MD. 2176 | 59 | | |
| Baltimore, | Pages 1 nent of He nt: If then nry or oth | | 20a. Method of Disposition 1 ☐ Buriai 2X☐ Cremation 3 ☐ | Removal from State | 20b. Placa of cametery | Disposition (Ne r, cremetory or o | me of other ple | ce) | Data | 20c. Location - | City or To | own, State | |
| Ē | tment: tant: | | 4 ☐ Donetion 5 ☐ Other (Specia | y) S | Smiths | ourg Cre | | - Y | 1/22 | Smithsbu | ırg, | MD. | |
| Ba | permit. Pag Department Important: It any injury o | | 21. Signature of Funeral Service Lice | 71-6 | | Donal o | Addre | Thompso | on Funer | al Home | | | |
| | | | 23 Part Estar the disease or a | plications that caused the | doath Don | | | | Middleto | | 2176 | | |
| | Physician | | neart failure. List only | ona cause on each line. | death. Don | ot entar the mot | ae or ayı | ig, such as care | lac or respiratory | arrest, | | Approximate Intarvai Batween Onset end Death | |
| | Physician /Medical | | Immediate Causa (Final | ADEND | CARCI | ANDUA | ^ | E PER | LICARD | Wm | | Cournelles | |
| п | Examiner | | disease or condition resulting in death) | a. Due | to (or as a c | onsaguanca of) | | 10. | | | | 6 worths | |
| - | D # | Examiner | _ | ADEN | DCAR | einon | ch | 3 6 | 2 mAR | 4 | | 6 months | |
| | and -trans | хаш | Sequentially list conditions, | 0. | | onsequenca of) | | | | 1 | | | |
| 68760, | tificate be executed ig physician and as the burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disase or injury that initiated accords | c | | | | | | | | | |
| 687 | ficate phys | edical | that initiated avants resulting in death) Last | Due | to (or as a co | onsequence of): | | | | | | | |
| Вох | anding use a | M/V | | d | | | | | | | | | |
| | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/W | Pert II. Other significant conditions of | ontributing to death but no | ot rasulting in | tha undarlying | ausa giv | ven in Part I. | 23b. Die | d tobacco uaa cor | ntribute t | o the cause of death? | |
| P. O. | d by ti | Phy | CEREBROVA | SCULAR 1 | Accer | 75N3C | | | 10 | Yes 20 No | 3 Pro | bably 4 Unknown | |
| ds, | signe d be d | l by | CEREBROVA ATRIAL F | | | | | | - | | 0.45 141 | 4-4-4-4-4 | |
| Ö | v require been si should | Completed | ATRIAL F | 1BRILLLA | TON | | | | | s an autopsy formed? | ev | era autopsy findings alleble prior to empletion of cause | |
| Re | has law | mp | | | | | | | | / | | death? | |
| a | certificate | | 25. Was case referred to medical | | | | | 00 Plans of 5 | | Yes 2 No | 1 | Yes 2 No | |
| > | s cert direct | To Be | examinar? | Hospital: | 2 ☐ ER/Out | patient 3□ D | Oth Oth | - | Deeth (Check only | sidance 6 □Oth | er (Specii | (v) | |
| 0 | g Phy er thi | | 27. Manner of Death | 28a. Date of Injury (Month, Day Ye | 28b. Ti | | 28c. Inju | | | how injury occurr | | ,, | |
| Ö | ath. yr: Aft | atio | 1 Natural 5 Panding 2 Accident invastigatio | n | | M | | Yes 2 □ No | | | | | |
| Division of Vital Records, | is after du si Direct ed in by t | Certification: | 3 Suicide 6 Could not b 4 Homicide datermined | | Af home, fan | m, streef, fector | y, office | | 28f. Location City or To | (Street and Numbown, Stete) | er or Rur | al Route Number, | |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edicai | 29e. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar | ysician: To the best of m ninar: On the basis of exa and mannar stated | mination and | deeth occurred /or investigation | at the ti | me, date and pla plnion, daath o | ce, and due to the curred at the time | e causa(s) and ma a, date end place, a | nnar as s and due t | stated. o tha cause(s) | |
| | Vithing Com | Σ | 29b. Signature and title of certifier | 00111 | 45 | 29 | 400 | a number | | 29d. Date signed | Month, | Day, Year) | |
| | | | live | esteru | | | D | 2048 | 8 | 1/28 | 100 |) | |
| | | | 011111 | dessler | MD | POR | | | | MIN, M | us. | 21769 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registraria | Signatura | 4 | | | | | | | |
| DHI | H 16 Ray 6/9 | | | 2 2000 | | Ø. | 19 | outs! | , | | | | |
| 2111 | | - | | | | | | | | | | | |

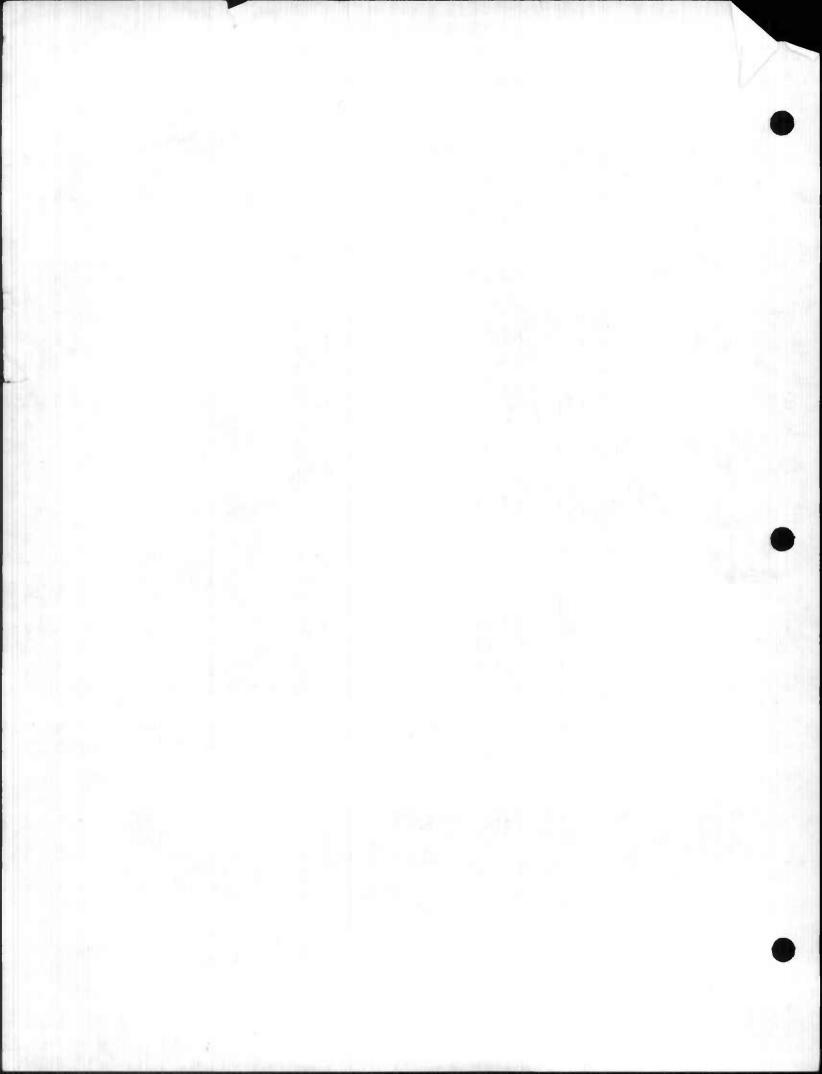


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| | | | Reg. No. | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|
| Physicia | | 2. Date | of Death 3. Time of Death lary 25 2000 1208 | | | | | | | | | |
| /Medica | william vernon Broderick | | | | | | | | | | | |
| Examine | | Easton | Death 4c. County of Death Talbot | | | | | | | | | |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeel | Hours Min. (Mont | of Birth h, Day, Year) 17, 1932 9. Birthplace (State or Foreign Country) Washington DC | | | | | | | | | |
| Pug . | Usuel Residence of Decedent 10a, State 10b, County 10c, City, Town or Location | | 10d. Inside City Limits | | | | | | | | | |
| se-f sho | Maryland Queen Anne's Stevensville | | 1 ☐ Yes 2 ☐ No | | | | | | | | | |
| ath with th | | | 10g. Citizen of What Country? USA | | | | | | | | | |
| 12 0020 | 1 Never Merried 25 Merried 1 1 Types 2 No. 49 - 1 Yes 25 No. 49 - | Specify: | or No- 2.) 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 21215-0020 21215-0020 d within 72 hours aff plene. r than "natural", or fr the manual front | Elementary/Secondary (0-12) College (1-4or 5+) | | 16b. Kind of Business/Industry | | | | | | | | | |
| D L S | | | Trucking | | | | | | | | | |
| d be find it ed out | | Anna Elizabet | | | | | | | | | | |
| Maryland 212 Maryland 212 d2 should be filed with tith and Mental Hygiene. T7 is marked other than traumatic event, the than | Social Security Number Social Security Numbe | et end Number or Rural Route N | Number, City or Town, State, Zip Code) | | | | | | | | | |
| Baltimore, IN Department of Health Important: If item 27 in any injury or other tr any injury or other tr | 15 Buriel 2 Cremetion 3 Removal from State cemetery, crematory or other plants | 15 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other place) Maryland National Memorial January 31, 2000 Laurel, MD | | | | | | | | | | |
| 6876(tificate be g physicia as the bur | 23a. Fant. Enter the disease, or complications that ceused the death. Do not enter the mode of dy shock, or heart failure. List only one ause on each line. Immediate Ceuse (Final disease or condition resulting in death) But to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | ring, such es cardiac or respirat | Approximate Interval Between Onset and Death His in Approximate Interval Between Onset and Death Approximate Interval Between Onset In | | | | | | | | | |
| P.O. BOX | Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse g | jiven in Pert I. 23b | Did tobacco use contribute to the cause of death? | | | | | | | | | |
| | Chiala I a a I Maria | | 1 Yes 2 No 32 Probably 4 Unknown Was an autopsy 24b. Were autopsy tindings | | | | | | | | | |
| Hecords, P.O. Box The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use | | 248. | Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? | | | | | | | | | |
| Vital Resident The Le | | | 1 ☐ Yes 2 ☐ No | | | | | | | | | |
| Si io | 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | ury at ork? 28d. Des | only one) Residence 6 Other (Specify) cribe how injury occurred | | | | | | | | | |
| Division of To the Hospital or Attending Ply within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral parts. | determined 208. Flace of frigury - At florite, fellit, Street, factory, office | | ition (Street end Number or Rural Route Number, or Town, State) | | | | | | | | | |
| ne Hospi n 24 hou ne Funeri pletely fill | 29a. Certifier (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my and manner stated. | time, date and place, and due t opinion, deeth occurred at the | to the cause(s) and manner as stated. time, date end ptece, and due to the cause(s) | | | | | | | | | |
| To the within To the Comi | 29b. Signature and title of certifier 29c. Licer | | 29d. Date signed (Month, Day, Year) 1 - 27 - 2000 | | | | | | | | | |
| | 30. Neme and address of person who completed cause of death (them 23a) (Type, Print) Dr. John Mastandrea 509 Idlewild Ave. Easton, | Maryland 21601 | | | | | | | | | | |
| State | 10N / X / 11111 \ | rocks | | | | | | | | | | |

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | Certifica | te of Death | Re | g. No. | 04394 |
|-----------------------------|--|---|---|---|---|---|---|
| hysician | Decedent's Nama (First, Middle, | 111 | 12 | | 2. Data of Death | 2800 Year | 3. Tima of Death |
| ledical iminer | Kasetta 4a Facility Nama (If not institution, | | 1 DV | 4b. City, Town, o | or Location of Death | 4c. County of Dea | |
| niner | Memorial Hosp | ital Easton | | Easton | | Talbot | |
| eral etor | 5. Social Security Number 157-01-3435 Usual Rasidenca of Decedent | . Sex 7. Age (In yrs. Ia | st birthday) If Und Month: | er 1 Year If Under 24 H s Days Hours M | | | thplaca (Stata or Foraign ountry) 1ary Jand |
| tor | 10a. State 10b. County | 10c. City, | Town or Location | 010 | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| Funeral Director | 10e. Street and Number | CI ANI | 106.2 | ip Code | 10 | g. Citizen of What C | ountry? |
| neral | 11. Marifel Stefus | 12. Was Decedent Ever in U,S | 2 U T | odent of Hispanic Origin? ecify Cuban, Mexican, Pu | (Specify Yas or No- | 14. Raca - Am | |
| b | 1 Nevar Married 2 Merried 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: | | ecity Cuban, Mexican, Pu | arto Hican, atc.) | Specify: B | la, atc. |
| eted | 15. Decedant's (Specify only highest (| Education grada completed) | 16a. Decedent's Us (Giva kind of w | rork done during most of w | orking 1 | 6b. Kind of Business | /Industry |
| Completed | Elemantary/Secondery (0-12) | College (1-4or 5+) | Ma. DO NOT | Λ / | and I | HONO | are |
| Be C | 17. Father's Name (First, Middla, La | st) | NURSI | | ama (First, Middle, M | | are |
| To B | Samuel | C. Green | | Elg | ie St | anlev | |
| | 19a. Informant's Name/Ralationship | (Type, Print) | 19b. Mailing Addre | ss (Street and Number or | 4 | | |
| | 20a. Mathod of Disposition | O Drown | ce of Disposition (N | ggins St, | E a Stor | oc. Location - dity or | Town State |
| | 1 D Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe | Hemovel from Stata | radise | Other place) | 2/07/2000 | TRappe. | |
| | 21. Signature of Funaral Sarvice Lie | | | and Addrass of Facility | | | |
| | Janelle | C Stenry | Henr | y Lunekal | Home P. St. Cant | ridge N | Varyland |
| , | 23a. Part Entar tha disaase, or co shock, or heart failure. List on | mplications that caused tha death. ly ona cause on each line. | Do not enter the me | ode of dying, such as card | iec or raspiratory erra | st, | Approximata Interval Between Onset and Death |
| il r | Immediata Causa (Final disaasa or condition resulting in death) | a. Cinibrova. | ular d | isunsu | | | hours |
| 5 | | Due to (or a | as a consequence of |): | | | ! |
| edicai Examiner | Sequantially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disaase or injury | b. Due to (or a | as a consequence of |): | | | 1 |
| edicai | Cause (Disaase or injury that initiated evants resulting in death) Last | cDua to (or a | s a consequence of |): | | | |
| an/Mec | | d | | | | | 1 |
| sici | Part II. Other significant conditions | confributing to death but not result | ing in the underlying | causa given in Part I. | 23b. Did tob | ecco uee contribut | e to the cause of death |
| Ph | the protestic | | | | 1 ☐ Ye | 8 2 No 3 F | Probably 4 d-Unknow |
| Completed by Physician/ | | | | | 24a. Was en | | Wara autopsy findings available prior to complation of causa of death? |
| | | | | | 1 □ Yas | 2 1 No | 1 Yes 2 No |
| ошо | | | | | | | |
| Be Comp | 25. Wes casa rafarred to medical | | | 28. Place of C | eeth (Check only ons | 1 | |
| To Be | axaminar? 1 ☐ Yas 2 ☐ No | | R/Outpatient 3 | OOA Other: 4 Nursing | Homa 5 ☐ Rasider | nca 6 Othar (Spi | ecify) |
| To Be | axaminar? 1 Yas 2 No 27. Menner of Death 1 Poeturel 5 Pending | 28a. Data of Injury (Month, Day Year) | R/Outpatient 3 0 0 | Other | | nca 6 Othar (Spi | ecify) |
| To Be | axaminar? 1 Yas 2 100 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 8b. Time of Injury | OOA Other: 4 Nursing 28c. Injury at Work? 1 Yas 2 No | Homa 5 Rasider 28d. Describe hor | nca 6 Other (Spewinjury occurred | |
| cation: To Be | axaminar? 1 | 28a. Diate of Injury - At hom- | 8b. Time of Injury M a, farm, street, fector | OOA Other: 4 Nursing 28c. Injury at Work? 1 Yas 2 No | Homa 5 Rasider 28d. Describe hor 28f. Location (Str. City or Town.) | nca 6 Other (Spewinjury occurred set and Number or R Stete) | iural Routa Number, |
| To Be | axaminar? 1 Yas 2 No 27. Manner of Death 1 Neturel 5 Pending invastigat 3 Suicida 6 Could not determine 29e. Certifier 1 Certifying F | 28a. Data of Injury (Month, Day Year) 28a. Plece of Injury - At hombuilding, etc. (Specify) Phyeician: To the best of my knowlerminer: On the basis of examinetic | 8b. Time of Injury M Ma, farm, street, fector edge, death occurren and/or investigation | OOA Other: 4 Nursing 28c. Injury at Work? 1 Yas 2 No only, office dat the time, date end plain, in my opinion, daath oc | 28d. Describe hor 28f. Location (Str. City or Town, ce, end due to the cacurred at tha tima, de | nca 6 Other (Spewinjury occurred set and Number or R Stete) | iural Route Number, s stated. e to the cause(s) |
| cation: To Be | axaminar? 1 Yas 2 No 27. Manner of Death 1 Neturel 5 Pending invastigat 3 Suicida 6 Could not determine 29e. Certifier (Check only one) 1 Yas 2 No 5 Pending invastigat 6 Could not determine | 28a. Data of Injury (Month, Day Year) 28a. Plece of Injury - At hombuilding, etc. (Specify) Phyeician: To the best of my knowlerminer: On the basis of examinetic | 8b. Time of Injury M Ma, farm, street, fector edge, death occurren and/or investigation | OOA Other: 4 Nursing 28c. Injury at Work? 1 Yas 2 No only, office | 28d. Describe hor 28f. Location (Str. City or Town, ce, end due to the cacurred at tha tima, de | w injury occurred eet and Number or R Stete) use(s) and menner at and place, and du | iural Route Number, s stated. e to the cause(s) |
| edical Certification: To Be | axaminar? 1 Yas 2 No 27. Manner of Death 1 Neturel 5 Pending invastigat 3 Suicida 6 Could not determine 29e. Certifier (Check only one) 29b. Signatura end title of certifier 30. Nama and addrass of person wh | 28a. Data of Injury (Month, Day Year) 28a. Plece of Injury - At hombuilding, etc. (Specify) Physician: To the best of my knowlers and manner stated. | 8b. Time of Injury M a, farm, street, fector edge, death occurre n and/or investigation 3a) (Type, Print) | OOA Other: 4 Nursing 28c. Injury at Work? 1 Yas 2 No only, office dat the time, date end plan, in my opinion, daath oc 3c. License number | 28d. Describe hor 28d. Location (Str. City or Town. | nca 6 □Othar (Special Control of the Control of th | iural Route Number, s stated. e to the cause(s) |

obs. Higgins St. Eas.

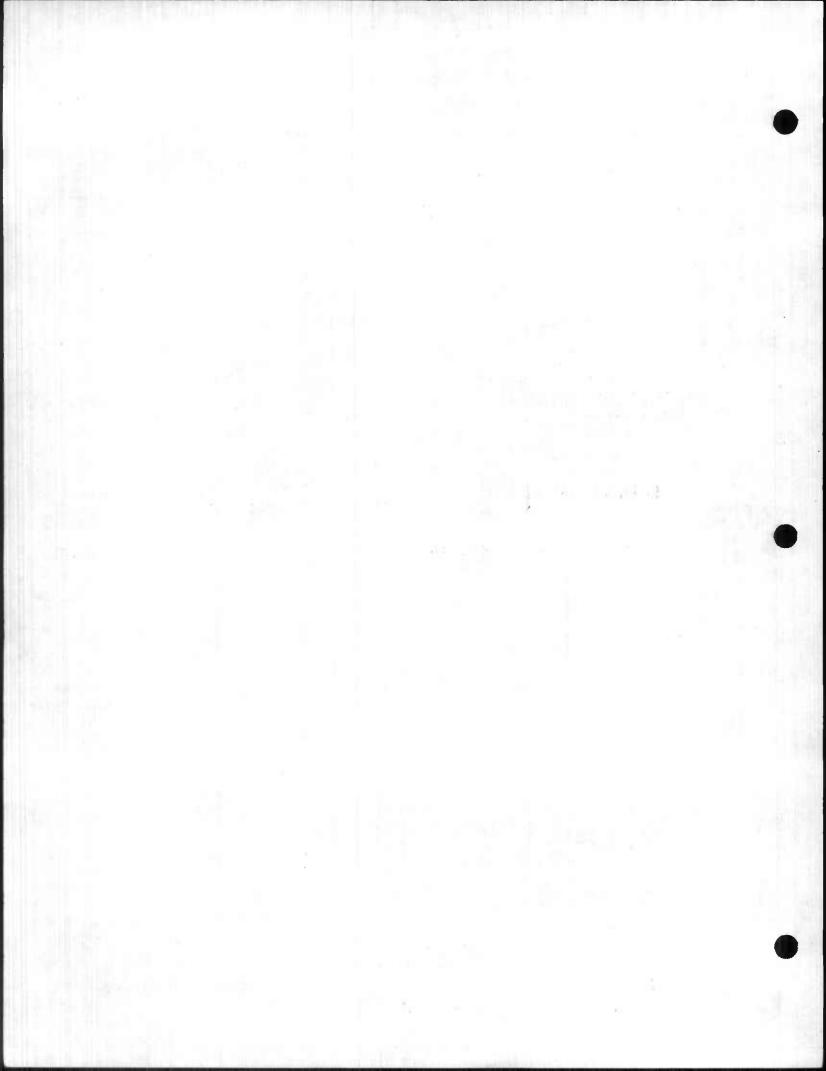
odise Cenetery aforfacootrappe, Mary.

Henry Funeral Home P.A.

stowashington St. Cambridge, Maryland

State of Maryland / Department of Health and Mental Hygiene 04395 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 28, 2000 5:45 AM Russell Samuel Barthlow /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Health Care Center Frederick 5. Social Security Number 214-10-5432 If Under 24 Hrs 8. Date of Birth Month, Day, Year) Jan. 31, 1914 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year 6. Sex XXM 2□ F 9. Birthplace (State or Foreign **Funeral** Days Maryland Director Usual Residence of Decedent the Meryland Ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Meryla neat of Health and Mental Hyglens.
Int: If Heart 27 is marked other than "natural", or itema 23a or 28a-f ahow mit; If ham 27 is marked other than "natural", or other traumatic avant, in a second Examination to be notified. Frederick XXYes 2 No Frederick Director Maryland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 259 Wyngate Drive 21701 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes ₹ No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heating and Air Condition Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Elizabeth Frances Burke Millard Barthlow Ernst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 259 Wyngate Drive, Frederick, Md. 21701 Mrs. Courtney Barthlow, wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery, Feb. 1, 2000 Frederick, Maryland permit. Pege Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Keeney and Basford PA Funeral Home DUG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kickard 21701 Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final Bladder & Colon Cancer (neoplasms) 8 years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 687 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic Airway Obstruction; 2 Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Kidney & Ureter Disease paga 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attanding Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funarai 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 ⊠Natural To the Hospital or Attandir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 Yes 2 No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of comile 29c. License number 29d. Date signed (Month, Day, Year) January 28, 2000 144 of death (Item 23a) (Type, Print) 30. Name and address of berson who 31. Date filed (Month, Day, Year) State JAN 3 1 2000

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JAN. 18 2000 13:40 pm WANDA NICHOLS BOWEN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Months Days Hours 1965 Director July 13 217-86-6290 permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examinar has nontrived above. 10n. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Poolesville Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20837 19220 Hempstone Ave. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: white Specify: p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Dispatcher Trash Service Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Thomas F. Nichols Elsie Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elsie Zalinski/mother 19220 Hempstone Ave. Poolesville, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Monocacy Cemetery 1/22 Beallsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hilton Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 Approximata Interval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION 60 min. Examiner Due to (or as a consequence of): Physician/Medical Examiner CARDIOMYOPATHY physician and the burial-transit vears The lew requires that the death certificate be assorted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): DIABETES MELLITUS years that initiated events resulting in death) Last Due to (or as a consequence of): USE AS 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 | Inpatient 2 | ER/Outpatient 3 | DOA edical Certification: To After this 27. Maryner of Death 1) El Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760. P.O. Records, of Vital Hospital or Attanding Physician: To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Division

Bower

5 Pending investigation 1 Yes 2 No 2□ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

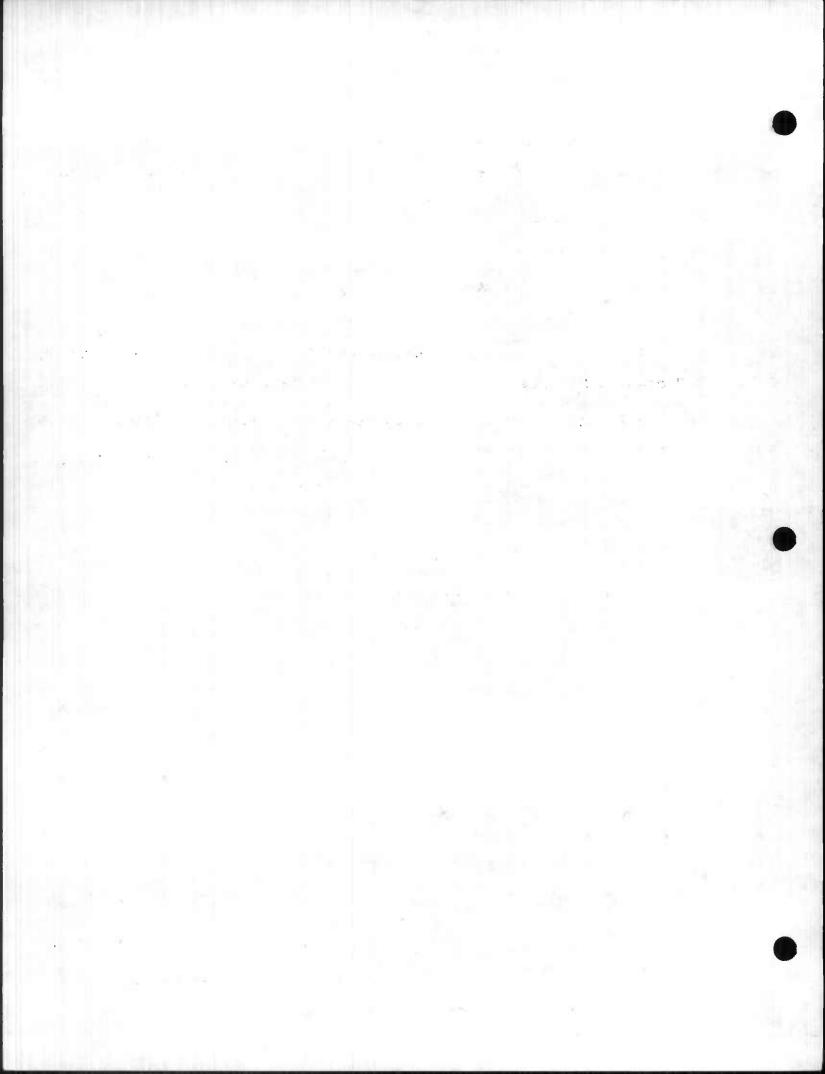
29d. Date signed (Month, Day, Year)

JANUARY 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRETT GAMMA 9901 Medical Center Dr. Rockville, MD 20850

State Registrar



Physician Examiner the death certificate be executed Box 68760 P.O. Division of Vital Records. or Attending Physician: To the Hospital o within 24 hours at To the Funeral Di completely filled is

Physician

/Medical

Examiner

Directo

Funeral

89

Funeral

Director

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Berns 23a or

matural, or

altimore, Maryland 21215-0020

Pages 1 and 2 should be Hoalth and Mental

mportant: If Item 27 is marked

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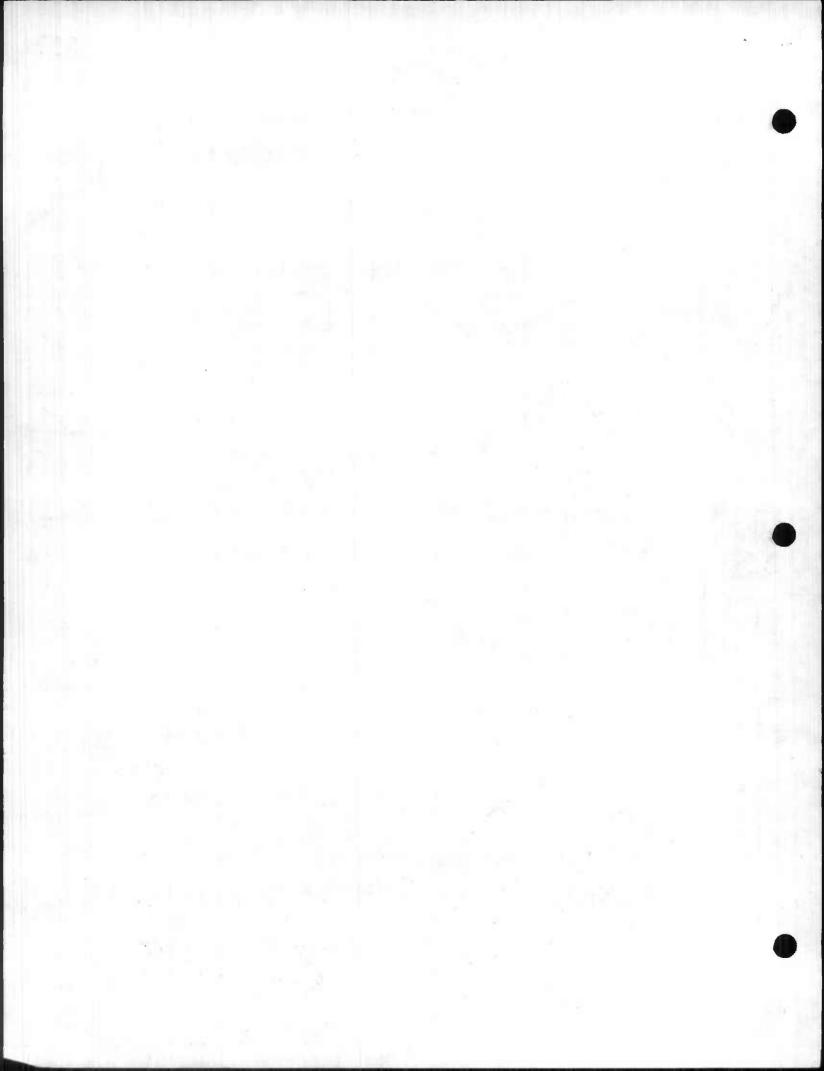
Charlotte

State Registrar er57

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

2000

32. Registra Signeture



Amended Items 7 & 10e per F.D, Amended Items 27 & 29c per Phy., 02/01/2000, Carroll County Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LOIS, BARTH 2000 12:16 AM 30 0 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SYS If Under 1 MARYLAND MED BALTIMORE UNIVERSITY If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 238-07-6954 76 Yrs. 78 Director 192/ North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits flied within 72 hours after death with the Marylan Hygiens Usan Institutel, or Herrs 23s or 28s-f show orth the Marilas Essenties mant be notified as Maryland Howard Woodbine 1 ☐ Yes 2 No Director 10s. Street and Number 15550 Morgan Woodbine Rd. 10a, Citizen of Whet Country? 10f. Zip Code Morgan Woodbine Rd. 21797 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t 4. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baitimore, Maryland 21215-0020 White 1 ☐ Yes 2 ₺ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Heelth and Mentel Hygiens Important: If Nem 27 is marked other true eny Injury or other traumatic aware see. 2 years Secretary Liberty Mutual Ins. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Daniel Elliott Alma Inman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Frank III (Son-inlaw) 16460 Old Frederick Rd. Mount Airy, MD 21771 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State Poplar Springs Cemetery 2/3/2000 Poplar Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. ller 1212 West Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical lumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner BACTEREMEA MRSA physicien and the buriel-transit the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury SMALL Box 68760. BOWEL OBSTRUCTION that initiated events resulting in death) Last US0 88 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yee 2 No 3 Probably 4 Unknown The lew requires that Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 0 No After this certificate 1 Yes 1 Yes 2 No of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Certification: To funeral To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Diractor: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide Conid Hor be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide to the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 P13400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) FEB 0 1 2000

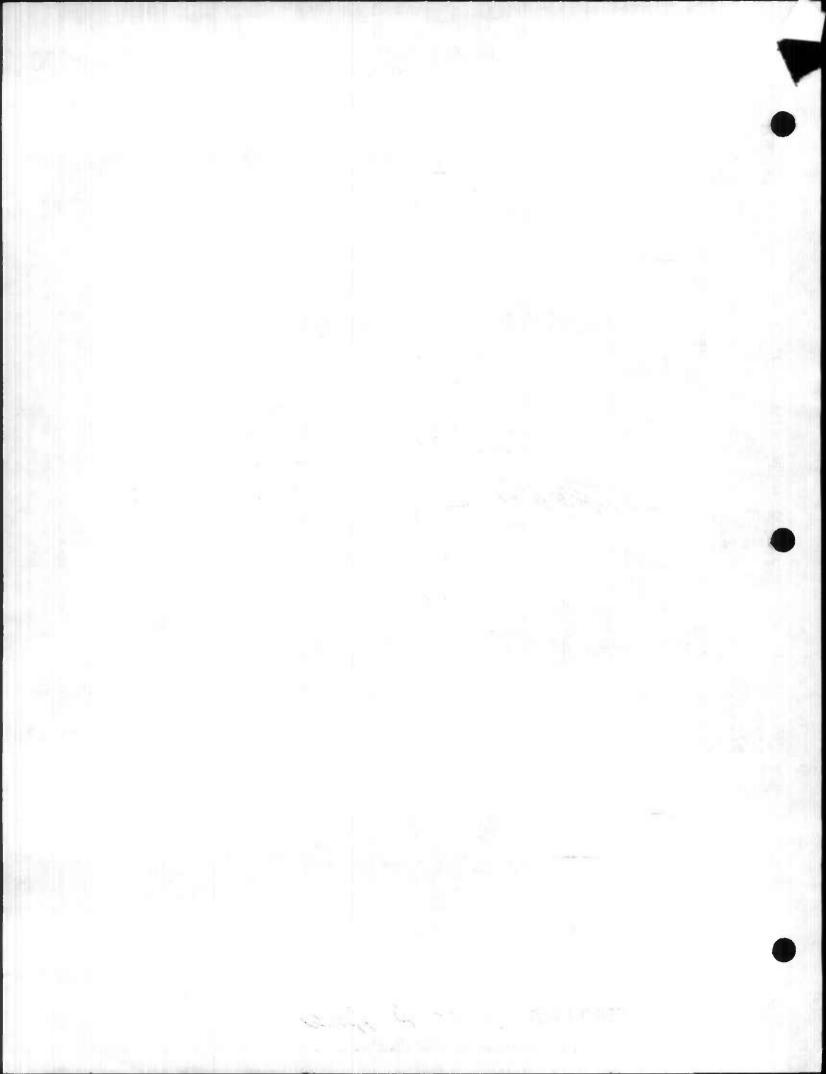
NOW YGA

32. Registrar's Signature

, umms

B. Sporks

22 S. Greene Street, Baltimore, MD 21201

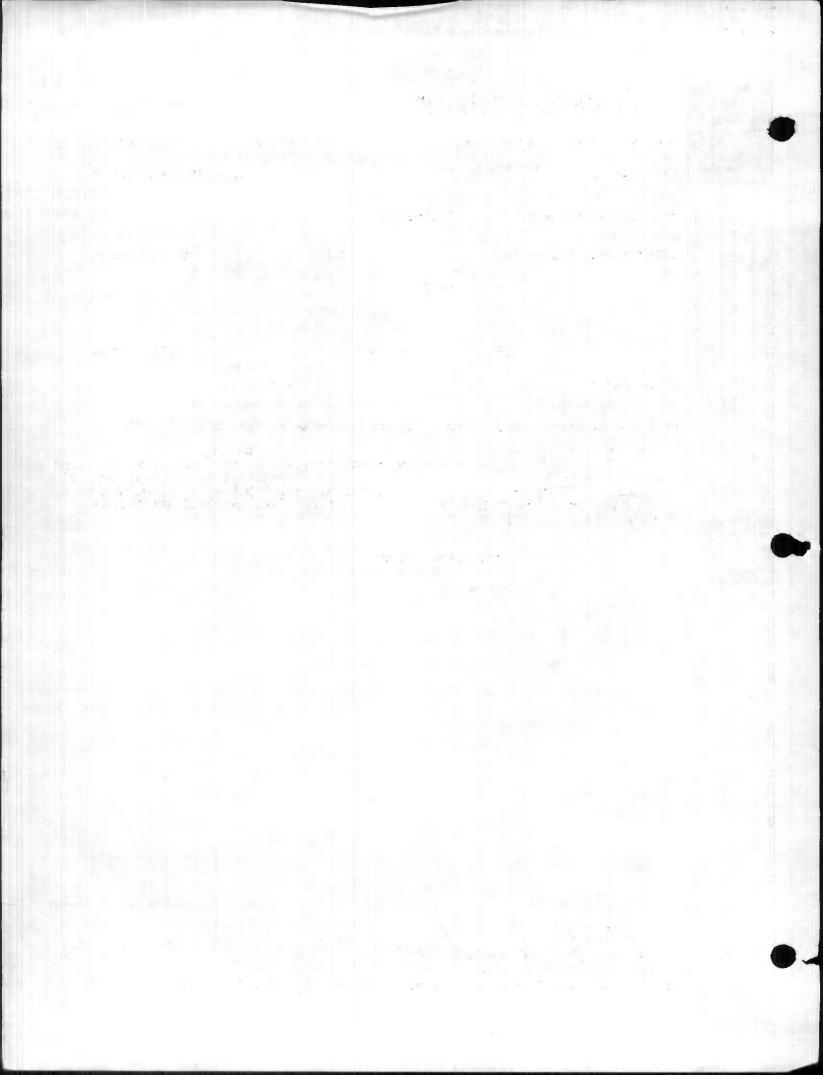


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State of Maryland / Department of Health and Mental Hygiene

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| | | | C | ertificate of | Death | | Reg. | No. | | |
|--|--|---|--------------------------------|--|--------------------------|-----------------|---|-----------------|---------------|--------------------------------------|
| | 1. Decedent'e Neme (First, Middle, L | ast) / / A - | | | | | e of Deeth | 2 | | 3. Tima of Death |
| Physician | HI)W/ARI | | Month | | | 29 20 00 Z | | 8:100 | | |
| /Medical Examiner | 4e Fecility Neme (If not institution, g | ive street and number) | | | 4b. City, Tow | m, or Location | of Deeth | 4c. County of | | - 101 |
| Examiner | Potomac Valley N | ursing Home | | , | Rockvi | 110 | | Montos | | |
| E | | | yrs. lest birthd | 1 0 11 1 1 1 1 | | | e of Birth | Montgo | | ce (State or Foreig |
| Funeral Director | | | 34 Yrs | Months Devs | Hours | | e of Birth onth, Dey, Ye | | | ce (State or Foreig |
| | Usuel Residence of Decedent | | | | | | | | | ork |
| anyland show | 10a. State 10b. County | 10c | . City, Town or | Location | | | | | 10d | d. Inside City Limit |
| Many Tor | Maryland Montgomery Rockville | | | | | | | | | 1 ☑ Yes 2 ☐ N |
| vith the Ma | 101. Zip Code | | | | | | | Citizen of Wh | net Country | v? |
| items 23. | 1235 Potomac Valley Road 20850 | | | | | | | nited S | | |
| | 11. Meritel Stetus | in U,S. 1 | 3. Was Decedent of | | in? (Specify Ye | | | - American | | |
| | 1 Never Merried 2 Married | Armed Forces? | | if Yes, specify Cuben, Mexican, Puerto Ri | | | ican, etc.) Bleck, Wi | | , White, etc | c. |
| d within 72 hours aft piece. It than "naturel", or it waden Exam. | 3 ☐ Widowed 4 ☐ Divorcad | 1 ⊠ Yes 2 □ No W If Yes, Give Yeer or Detes: | 11 | 1 ☐ Yes 2 ☑ No Specify: | | | | Specify: | Whi | ite |
| ture | 15. Decedent's | | 18e. De | cedent's Usuei Occu | petion | | 168 | b. Kind of Bus | iness/indu | etry |
| ed within 72 ho ygiene. wr than *nature ft, the Wedical | (Specify only highest g | rade completed) | (G | ive kind of work done | during most | of working | | | | |
| with than one | Elementery/Secondery (0-12) | College (1-4or 5+) 5+ | Te | acher | | | Pı | blic S | Schoo' | 1s |
| Hygie Hygie Co | 17. Fether's Neme (First, Middle, Las | it) | | | 18. Mother | 's Name (First, | | | | |
| d 2 should be flie th end Mentel Hy 7 is marked othe traumatic event | | | | | | n Welch | | | | |
| ges 1 and 2 should be filed within 72 ho to f Health end Mentel Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical To Be Completed | 19e. informent's Neme/Reletionship | Tuna Print) | 40L 14 | eiling Address (Stree | | | Number | iby or Town C | teto Zin C | 'orde) |
| 12 sho h end ls me traum | | | | Billing Address (31/86 | t and redition | or nurar noute | rvaniber, C | ity or Town, S | nare, zip O | 000) |
| ss 1 and of Health item 27 other tr | Evelynne L. Carp | | | Smallwood | Road | | | | | Chair |
| of H | 20e. Method of Disposition 1 ☐ Burlet 2 ☒ Cremetion 3 | | cemetery, | sposition (Neme of cremetory or other plant | eca) | Dete | | c. Location - C | ity or rowi | n, Stete |
| Pa nry | 4 □ Donetion 5 □ Other (Spec | | lontgome: | y Crematori | um, Inc. | Feb. | O Bet | hesda. | Mary | vland |
| permit. Page Depertment of Important: If any Injury or once. | 21. Signature of Funerel Service Lice | poop / | | 22. Name end Addr | ess of Fecility | Robert | A. Pu | mphrey | Fune | eral Hom |
| Dep June Suny Suny Suny Suny Suny Suny Suny Suny | XAAn L. T | M0068 | 0 | Rockville | Inc. | 300 We | st Mor | tgomer | v Ave | |
| - | 23a. Parti Farer de diseese, or col | mplications thet caused the c | | enter the mode of dy | ockv11 ing, such es o | le, Mar | yland retory errest | 20850- | A | Approximate |
| Dhysisian | affocks of hear talure. List only | y one cause on each line. | | | | | | | | nterval Between Onset and Deeth |
| Physician /Medical | Immediate Ceuse (Final | | | | | | | | | |
| Examiner | disease or condition resulting in deeth) | a Respirat | ory Ar | rest | | | | | 1 | |
| - b | | Due t | to (or es e con | sequenca of): | | | | | | |
| nin nin | Line Land Control | b. Pneumoni | .a | | | | | | i | |
| death certificate be executed a attending physician and of for use as the burial-transit sician/Medical Examiner | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c. | | | | | | | | | |
| g physician a as the burial | cause. Enter Underlying Cause (Diseese or injury | C | | | | | | | i | |
| death certificete be a tending physicis of for use as the but claran/Medical | that initiated events The control of the control o | | | | | | | | | |
| # 0 e E | | d | | | | | | | | |
| that the death cered by the attendir detached for use | | | | | | | | | | |
| tha a hed f | Part II. Other eignificant conditions | contributing to death but not | resulting In th | e underlying cause g | iven in Pert I. | 23 | 3b. Did toba | cco uee cont | tribute to ti | he cause of death |
| that the ed by th detache | | | | | | | 1 🗆 Yee | 2□ No | 3 Probe | bly 4 🖫 Unkno |
| S 58 G | | | | | | | | | | |
| been sign should be | | | | | | 24 | e. Wes en e | autopsy d? | eveil | e autopsy findings lebie prior to |
| ne law require a has been si age 2 should I | | | | | | | | | of de | pletion of cause seth? |
| 0 - 6 - | | | | | | | 1□ Yes | 2X No | 10 | Yes 2□ No |
| certificata rector, par | 25. Wes case referred to medical | T | | | Of Diago | of Deeth (Chec | | | | |
| Physician: The this certificate rel director, page Cc | exeminer? | Hospital: | • C = D = 0 | | her: | | | а Пон | (0:4:) | |
| His F | 1 ☐ Yes 2 ☒ No | | 2 ER/Outpa | tient 3LI DOA | 4 🖾 NUI | rsing Home 5 | | | | |
| tal or Attending Ph is after death. al Director: After the led in by the funeral Certification: | 1 ⊠Neturel 5 ☐ Pending | (Month, Dey Yea | (Month, Dey Year) injury Work? | | | | 8d. Describe how injury occurred | | | |
| Attending r death. •ctor: After by the fune iffication | 2 Accident investigati 3 Suicide 6 Could not | va | | | | | | | | |
| or Attending after death. Director: After din by the fune ertificatior | 4 ☐ Homicide determine | 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) | | | |
| | | | | | | | | | | |
| ne Hospital n 24 hours ne Funeral pletaly filled | | hyeician: To the best of my aminer: On the basis of exam | | | | | | | | |
| the F | one) | and manner stated. | 7 | and the second | | | | | | |
| vithin 2 To the comple | 290. Signature and the of certifies | () / | / | | se number | | | . Dete signed | | |
| 12+1 | 1/1/- | - Venal | cus | D522 | 261 | | Ja | nuary | 30, 2 | 2000 |
| 12 | 30. Name and address of person who | o completed cause of deeth (| (Item 23a) Ty | pe, Print) | | | | | | |
| | | CONTRACTOR OF THE PARTY OF THE | / | | | | | | | |
| | Alan Segal M D | 1299 Vambort | on Mrd | ve. Silvar | Snrin | o. MD | 20902 | | | |
| State | Alan Segal, M.D. 31. Dete filed (Month, Day, Yeer) | 1299 Lambert | | ve, Silver | | ng, MD | 20902 | | | |



3. Time of Deeth

1:00 PM

1 Yes 2 No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1 Decedent's Neme (First Middle I ast) Month January 26, 2000 Physician Irving Baker Marion /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) & Examiner HOSPITAL | HUnder 1 Year SHADY GROVE ADVENTIST ROCKVILLE MONTGOMERY 8. Dete of Birth 9. (Month, Dey, Year) 1917 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 6 Sex **Funeral** Months Min. 1√2 M 2□ F Deys Hours 174-18-2626 Director Usuel Residence of Decedent 10d. fnside Clty Limits 10a. Stete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Exeminer must be notified at with the Maryler MD Montgomery Gaithersburg Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 117 Water Street 20877 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indien. 11 Merital Stetus Bleck, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours efter Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite many injury or other traumatic avent, the Medical Examina page. 1 X Yes 2 No If Yes, Give W Year or Detes: 1 Never Married 20 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 217 No Specify: White Specify: 2 Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed)

17. Father's Neme (First, Middle, Lest)

Elementery/Secondary (0-12)

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efter deeth.

certificate be executed ettending physician end for use es the buriel-tran 18 Mother's Name (First Middle Meiden Sumeme)

Elmer C. Baker 19e. Informent's Neme/Reletionship (Type, Print) Verna B. Latta

1/29/00

Violet M. Baker - Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 117 Water Street Gaithersburg, MD 20877

20e. Method of Disposition XBurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Everett Cemetery

Carpenter

20c. Location - City or Town, Stete

Construction

Everett, PA

21. Signature of Funerel Service Licensee

College (1-4or 5+)

22. Name end Address of Feellity
Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310 First 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident Due to (or es e consequence of):
Acute Myocardial Infarction 1 week 1 week

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest

Due to (or es e consequence of): Heart Block

1 week

Due to (or es e consequence of): Renal Insufficiency

1 week

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown

24e. Was en eutopsy performed?

24b. Were autopsy findings evelleble prior to completion of cause of death?

1 Yes XXNo

26. Place of Death (Check only one)

1□ Yes 2XXX

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☐ No 27. Menner of Deeth

1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

29e. Certifier (Check only one)

14 Netural

2 Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifit

D.R. Rosing, MD

29c. License number 032193 29d. Date signed (Month, Dey, Year) 00

Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
D.R. Rosing, MD 9715 Medical Center Dr. #530 Rockville, MD 20850

Registrar

31. Dete filed (Month, Day, Yeer) FEB 03 2000

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture

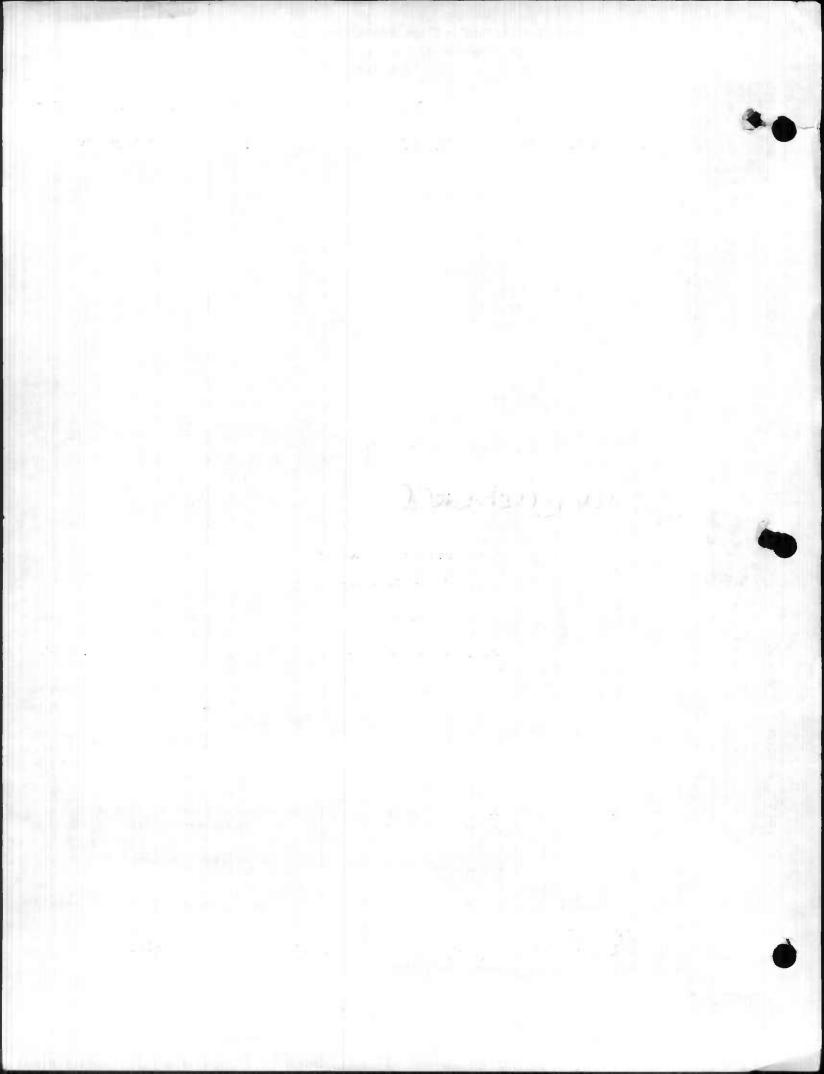
souls

DHMH 16 Rev 6/95

Box 68760. P.O. Division of Vital Records.

or Attending

filled in by Hospital within 24 hours of To the Funeral I completely To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:56PM 2000 Kichmond 4b. City, Town, or Location of Death /Medical 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) **Examiner** Hospita 5. Social Security Number Baltimore Baltimore MI If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Year 9. Birthplace (State of Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F Yrs. 58 463-62-0489 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show the Maryta the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director D.C. NONE WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20016 Funeral 3719 ALBEMARIE ST. N.W. U.S.A. fled within 72 hours after death Wes Decedent of Hispenic Origin? (Specify Yes or No It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 MYes 2 □ No It Yes, Give Yeer or Dates: KOREAN 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes ZNO à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry 9 Elementery/Secondery (0-12) College (1-4or 5+) 12 COMPUTER SYSTEMS ANALYST FED. GOV'T 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be should be nd Mental is marked 2 EDWIN BERT BALLEW DILE pue 19e. tntormant's Neme/Relationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important of Health a any injury or other traus once. . Pages 1 and 2 s mant of Health an #10 JACQUELIN BALLEW/WIFE SAME AS TITEM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/00 4 ☐ Donetion 5 ☐ Other (Specify) GLENWOOD CEMETERY WASHINGTON, D.C. 21. Signature of Funeral Service Ligensee 22. Name end Address of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) nyocaro Examiner Examiner or Attending Physician: The law requires that the death certificate be executed after death. as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Lest pue Box 68760. been signed by the ettending physician should be detached for use as the burie Physician/Medical Due to (or es e consequence of) P.O. 1 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy performed? has 1 Yes 2 X No 1 Yes 2 No certificate Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 10 1 ☐ Yes 2 No impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Menner of Death 28b. Time of After 5 Pending investigation 1 Neturel tnjun 1 Yes 2 No Director: A 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier 9+ 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) son 106 Battimore MO 21281 NorthWolfe Laura 32. Registrar's Signature 03

DHMH 16 Rev 6/95

State

Registrar

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04402 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Year Month GLADYS MARY BOWDEN JANUARY 29, 2000 6:00 A.M. 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Berlin Nursing and Rehabilitation Center Berlin Worcester If Under 24 Hrs. If Under 1 Year Months Days 7. Age (In yrs. last birthday) B. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 M 2 F 85 9/2/14 MD 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 9715 Healthway Dr. USA 21811 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 (No If Yes, Give Year or Detes: 1 Never Married 2 Merried Specify: white 1 Yes 2 No Specify: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Waitress Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Josh Bowden Lizzie (Unknown) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

8414 Langmaid RD Newark, MD

Cape Henlopen Crematory1/31/00 Frankford, DE

108 William St. Berlin, MD 21811

Date

20c. Location - City or Town, State

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to

Burbage Funeral Home

r than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at death v filed within 72 hours after "natural", or Baitimore, Maryland 21215-0020 Hygiene. permit. Peges 1 and 2 should be filled wif Department of Health and Mental Hygien, Important: If itsm 27 is marked other tha any injury or other traumatic event, the obdes.

BOWDEN, GLADYS

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

with the Maryland

5. Social Security Number

10e. Street and Number

10a. State

MD

11. Marital Status

218-12-1928

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

Immediate Cause (Finel

Bonnie Hunsucker

4 ☐ Donation 5 ☐ Other (Specify)

1 ☐ Burial 2 ØCremetion 3 ☐ Removel from State

10b. County

Usual Residence of Decedent

Physician /Medical Examiner

> physician and s the burial-transit USB signed by the a certificate this luneral

The law requires that the death certificate be asscuted

Box 68760.

P.O.

Division of Vitai Records.

Examiner Physician/Medical λq Completed 8 2 ne Hospital or Attanding Pi n 24 hours after death. The Funeral Director: Atter ti pietely filled in by the funera Certification: Medical compietely To the Pwithin 2.

diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

27. Menner of Death

2 Accident

3 Suicide

29a. Certifier

one

4 Homicide

(Check only

GREGORIO M.

Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical examiner?

mela

20b. Place of Disposition (Name of cemetery, cremetory or other place)

e, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each me.

Due to (or es a consequence of):

22. Name end Address of Facility

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

completion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: XXNursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

24a. Wes an autopsy performed?

🛣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dev. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7.29505

CHINABERRY DR; SALISBURY, MD 2180/

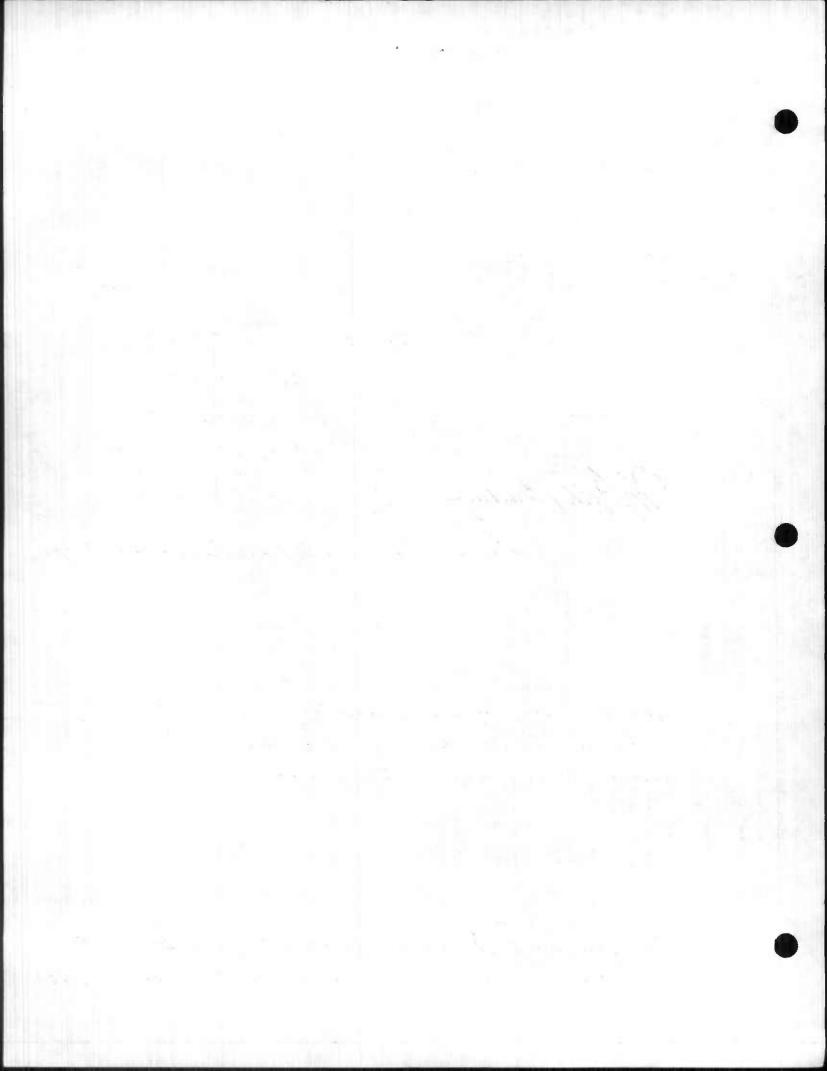
State Registrar

31. Date filed (Month, Day, Year) FEB 0 1

5 Pending

6 Could not be determined

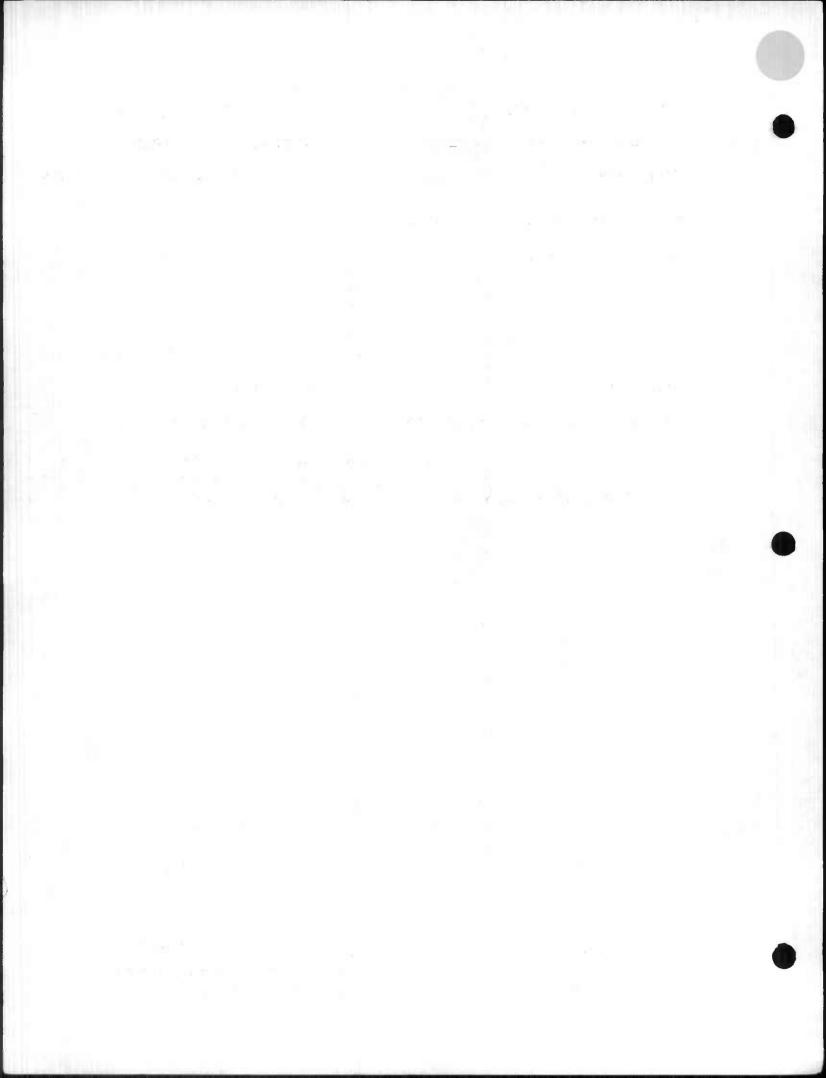
5302 BELLOSO, M.D. 32. Registrar's Signature Deneva



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State of Maryland / Department of Health and Mental Hygiene

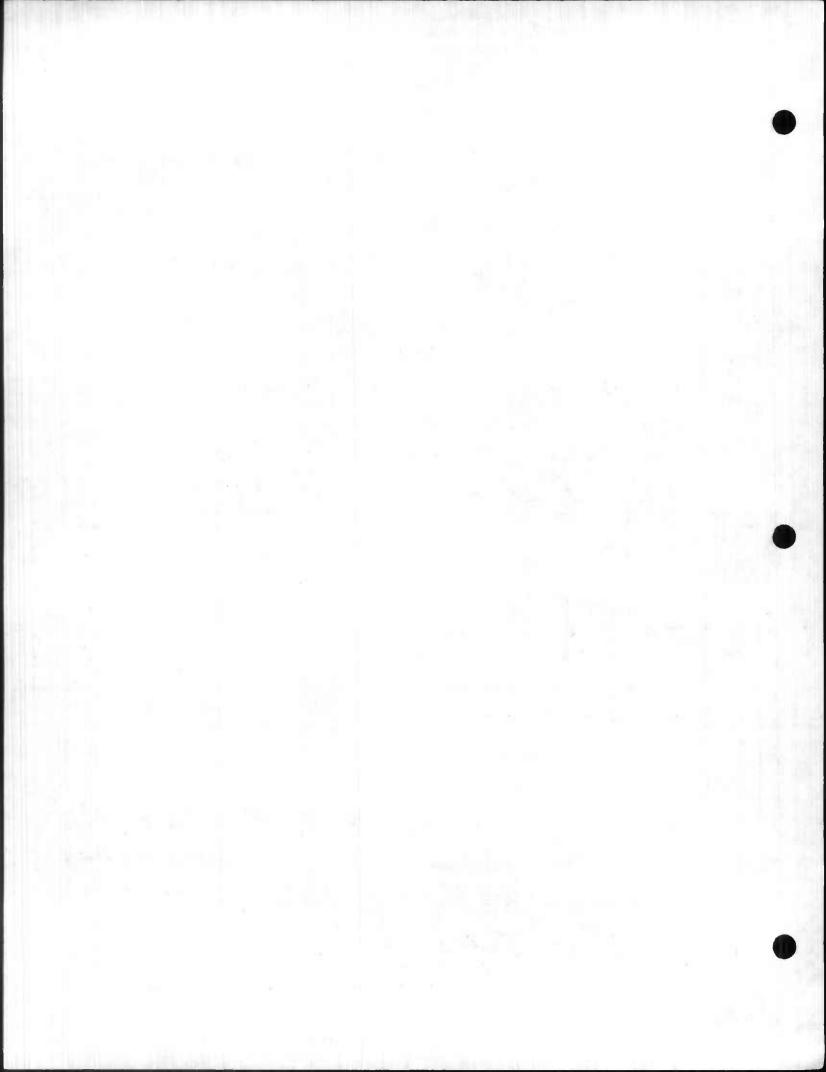
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month WILLIAM HARRIS BARBER JAN 2000 1:20 P.M. 25 /Medicai 4e. Fecility Neme (If not institution, giva street and number) 4h City Town or Location of Deeth 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8, Dete of Birth (Month, Dey, Ye March 9, 1 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 2□ F Deys 69 Yrs Director 031-22-1659 Massachusetts Usuei Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 23a-f show traumetic event, the Medical Examiner musk be notified at the Maryla 1 ☐ Yes 2K No Director Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19504 Gallatin Court 20886 United States Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be illed within 72 hours after Department of Healith and Mental Hygisms. Important: If liters 77 is marked other than "natural", or its any injury or other traumatic event, the Medical Examinate any injury or other traumatic event, the Medical Examinate. 1 🕅 Yes 2 □ No If Yes, Give Year or Detes: 1953--1984 1 ☐ Never Merried 2 X Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eigmentary/Secondery (0-12) Collage (1-4or 5+) 5+ Military Officer United States Navy 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Harris Barber Helen Carley 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) Kathleen Walker Barber/Spouse 19504 Gallatin Court, Montgomery Village, MD 20886 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Jan. 29 1 ☐ Buriai 2 MCremetion 3 ☐ Removel from Stete Montgomery Crematorium, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signeture of Funerel Service Licapes M00672 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceusa (Final disease or condition METABOLIC ACIDOSIS Examiner Dua to (or as a consequenca of): Examiner b. HIV burial-transit that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequenca of): attanding physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of). signed by the attaid Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à Completed 24a. Wes en autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of death? Deed page 2 has 2 No 1 ☐ Yes 2 No certificata Be 25. Was case rafarred to medical 28. Piece of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No ဥ Aftar this funaral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: Attending 1 Naturel 5 Pending investigation death. 1 Yes 2 Accident after death filled in by tha 3 ☐ Sulcide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral DI 29e. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, deta end piece, end due to the cause(s) end mennar as stated. Medicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stellad. 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Day, Year) 1251 yand 30+1 D0054450 MD 30. Nema and address of person who completed causa of death (Itam 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MARIA L JISON, MD BETHESDA, MD 20889-5600 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State FEB 2000 Registrar

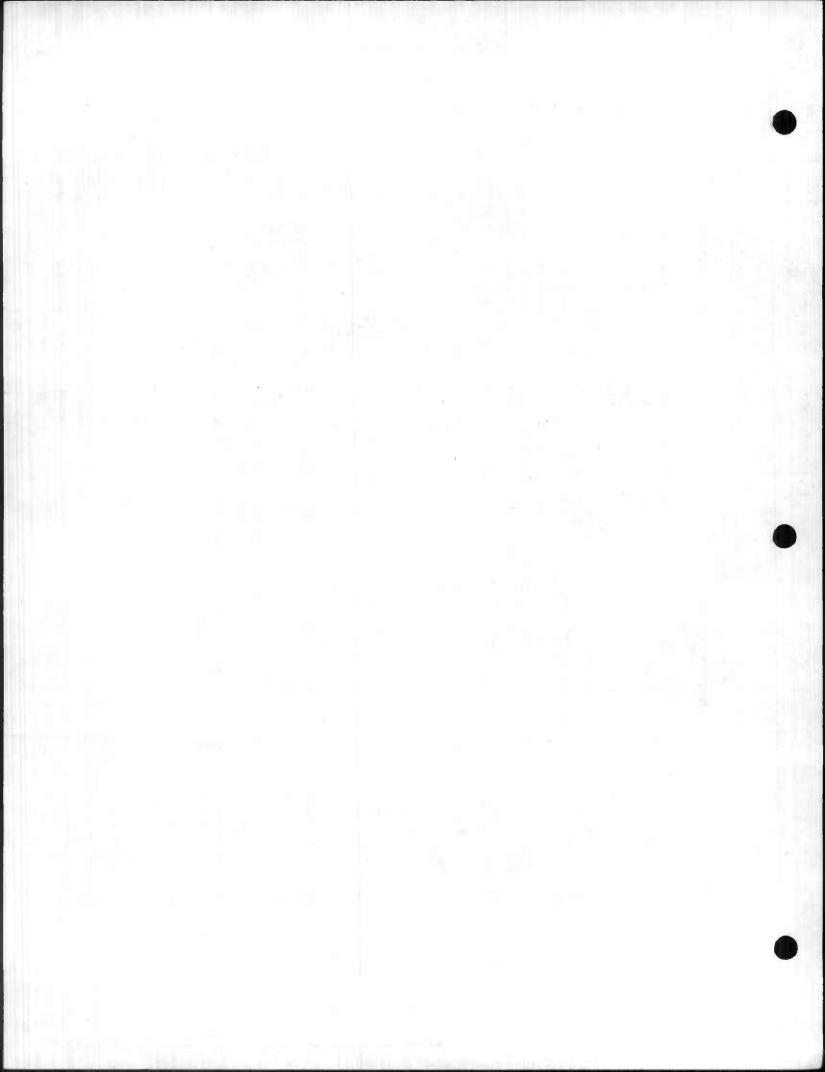


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 31, January 2000 Ruth Adams Bartley 5:30 am /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville ar Hunder 24 Hrs. s Hours Min. Montgomery Hospice- Casey House Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2X F Months Yrs. 83 Director 215-52-5098 Oct 13, DC Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show. me 23a or 28a-f short. 1 ☐ Yes 2 No Directo Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or items 23s or 15101 Glade Drive 20906 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status 72 hours after 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: White à 3 DAWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 abouid be filed wit Department of Health and Mental Hygieri Important: If Isan 27 is marked other tha any Injury or other traumetic event. the Homemaker Own Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Eleanor Marshall 2 Thomas Benjamin Adams 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Bartley/ Son 3500 Toddsbury Lane, Olney, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2/3/00 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Pert.f. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Lung Cancer 5 months Examiner Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be assoured Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): 88 for use as ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deed has page 2 1 Yes 2 No 1 Yes 2 No certificate of Vital Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 Yes 2 No Certification: To After this 28a. Date of tnjury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury et Work? Division Attending Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signeture and title of certifier 15 D09470 January 31, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Ave., Kensington, MD 20895 Eugene P. Libre, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 1 2000 souls Registrar

DHMH 16 Rev 6/95





Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. 04406 State of Maryland / Department of Health and Mental Hygiene \mathbb{U} Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 24, 2000 4:56 PM January Sylvia Wiznitzer Bildner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Mapleridge Assisted Living Facility Rockville Montgomery 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax Days Months Hours 1 M 2 K F 78 051-12-8210 Dec. 11, 1921 New York Usual Rasidenca of Decedan 10d. Insida City Limits 10a Stata 10b. County 10c. City. Town or Location 1 ¥ Yes 2 □ No **Rockville** Maryland Montgomery 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S.A. 20853 15908 Mapleridge Ct. 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 2 No If Yas, Giva Yaar or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 😾 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) Collega (1-4or 5+) Eiemantary/Secondary (0-12) Law Legal Secretary 18. Mothar's Nama (First, Middle, Maidan Sumema) 17. Fathar'a Nema (First, Middla, Last) Mollie Marmarosh Louis Wiznitzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Neme/Ralationship (Type, Print) 12213 Grove Park Ct., Potomac, MD 20854 Susan Trachman/ daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Jan. 28. 1 ☐ Burial 2 ☐ Cremation 3 X Ramoval from Stata Beth-El Cemetery Emerson, NJ 4 ☐ Donation 5 ☐ Othar (Specify) 2000 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. immediate Cause (Finel ALZHEIMER'S DISEASE Due to (or es a consequance of): Sequentielly list conditions, if any, leading to immadiate ceusa. Enter Underlying Cause (Disaasa or injury that initieted events rasulting in daath) Last Due to (or as a consequence of) Dua to (or as a consaquence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown OSTEOMYELITIS OF RIGHT FOOT 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy 1 Yes 2 No 1 TVas 2 No 25. Was cesa rafarrad to medicel axaminar? 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Asst. Liv. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No 28d. Describe how injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28e. Date of Injury (Month, Day Year) 5 Pending invastigation 1 X Netural 1 Yas 2 No 2 Accidant 6 Could not be determined 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 I Homicida 29e. Certifier 12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and menner as stated. 2 | Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at tha time, date end piece, and due to the causa(a) and mannar stated. (Check only one)

that the death certificate be executed P.O. Box 68760, Division of Vital Records, requires aw al or Attending Physician: T s after death. Il Director: After this certificat od in by the funeral director, p within 24 hours after To the Funeral Olre-completely filled in b Hospital 945

Physician

/Medical

Examiner

Directo

Funeral

Àq

Completed

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item 23a or 28a-4 show any Injury or other traumatic event, the Medical Exercities must be notified.

Physician /Medical

Examiner

physician and s the burial-transit

98 esn

signed by the e

been si

certificate hes t

Examiner

Physician/Medical

þ

Completed

Be

To

Certification:

Medical

29b. Signature and titla of corpline

altimore, Maryland 21215-0020

Registrar

30. Nama end addrass of person who completed cause of death (Itam 23e) (Type, Print) SALYON 3416

V3T

29c 1 icense number

29d. Data signed (Month, Day, Year)

JAnugen 26, 2000

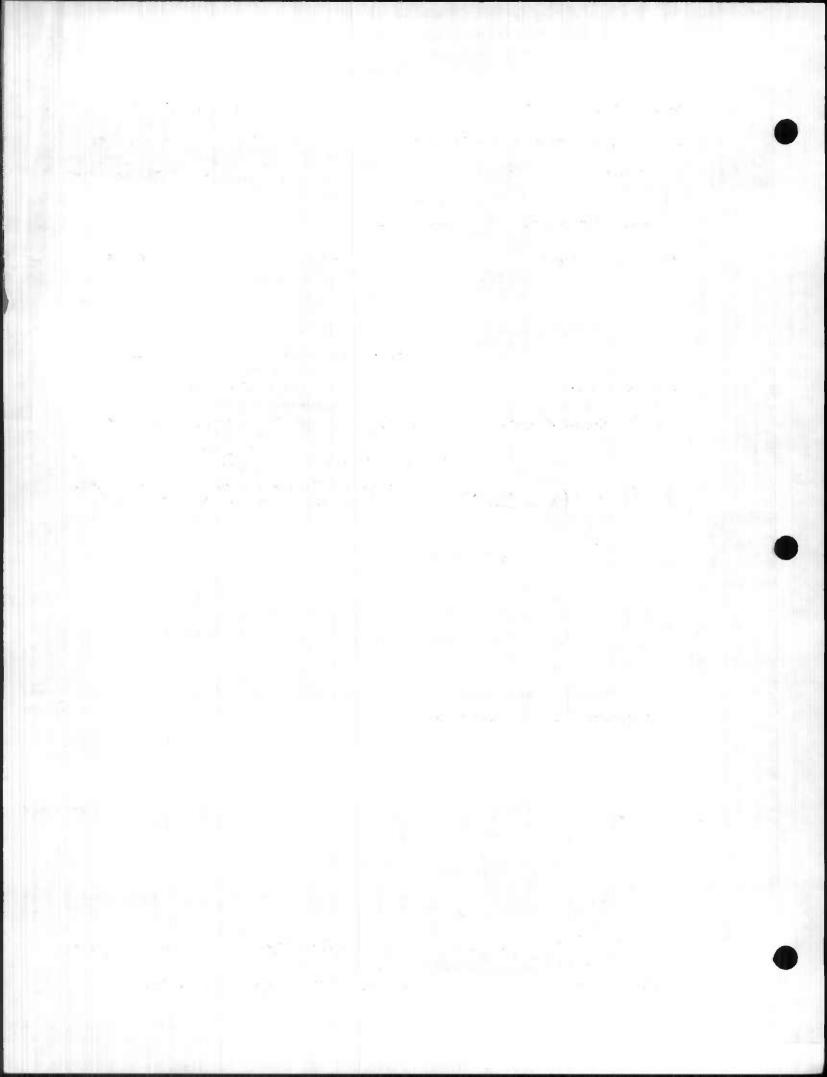
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32. Registrar's Signatura

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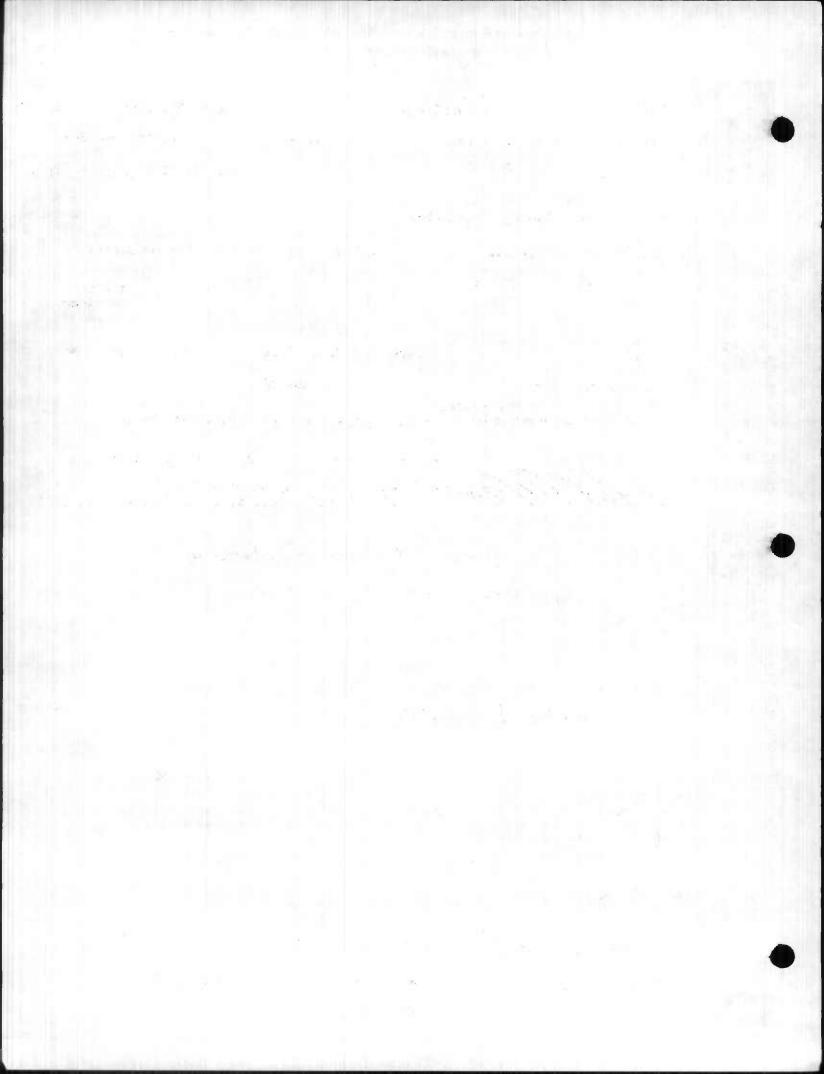
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. 1667. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** Janie ussingame 30, 2000 12:37 P.M. January /Medical 4a Fecility Name (If not Institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital Center 8. Date of Birth (Month, Pay, Year)
Jan. 13, 1919 South Carolina If Under 1 Year Months Deys If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** 1□M 201F Months Min. Hours Yrs. 579-16-5723 81 **Director** Usual Residence of Decedent the Menyland r 28a-f show inotified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with r than "natural", or items 23s or the Medical Examiner must be 20706 United States 8834 Glenarden Parkway Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, filed within 72 hours after 1 Never Married 2N Married 1 ☐ Yes 2 ☑ No If Yes, Give African Maryland 21215-0020 1 Yes 2 No Specify: P 3 Widowed 4 Divorced Yeer or Dates: American Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Specialist Federal Government Pages 1 end 2 should be filed nent of Health and Mental Hygi ent: If item 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Amy Odum Charlie C. Meyer 19e. Informent's Name/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Blassingame-Baccus Bowie, Md. 20720 11807 Lisborough Road altimore, 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Locelion - City or Town, Stete 1 Daurial 2 Cremation 3 Removal from Stete = 8 Department if 5 ☐ Other (Specify) 2/3/2000 Suitland, Md. 4 Donetion Lincoln Memorial 21. Signature of Funeful Service Line 22. Name end Address of Fecility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Myocadia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Coronag 9 ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): death certificete be exec physician s the burial Box 68760. Physician/Medicai Due to (or as e consequence of): 80 980 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 전 Unknown þ 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes en eutopsy completion of ceuse of deeth? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: director. Be 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ¥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending or Attending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

20 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) \$ 29b. Signature and 100 of pertifier 29c. License number 29d. Date signed (Month, Dev. Year) 0 2000 10 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) LN Carso MD Kowald mercaptile C Wheeler 1221 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

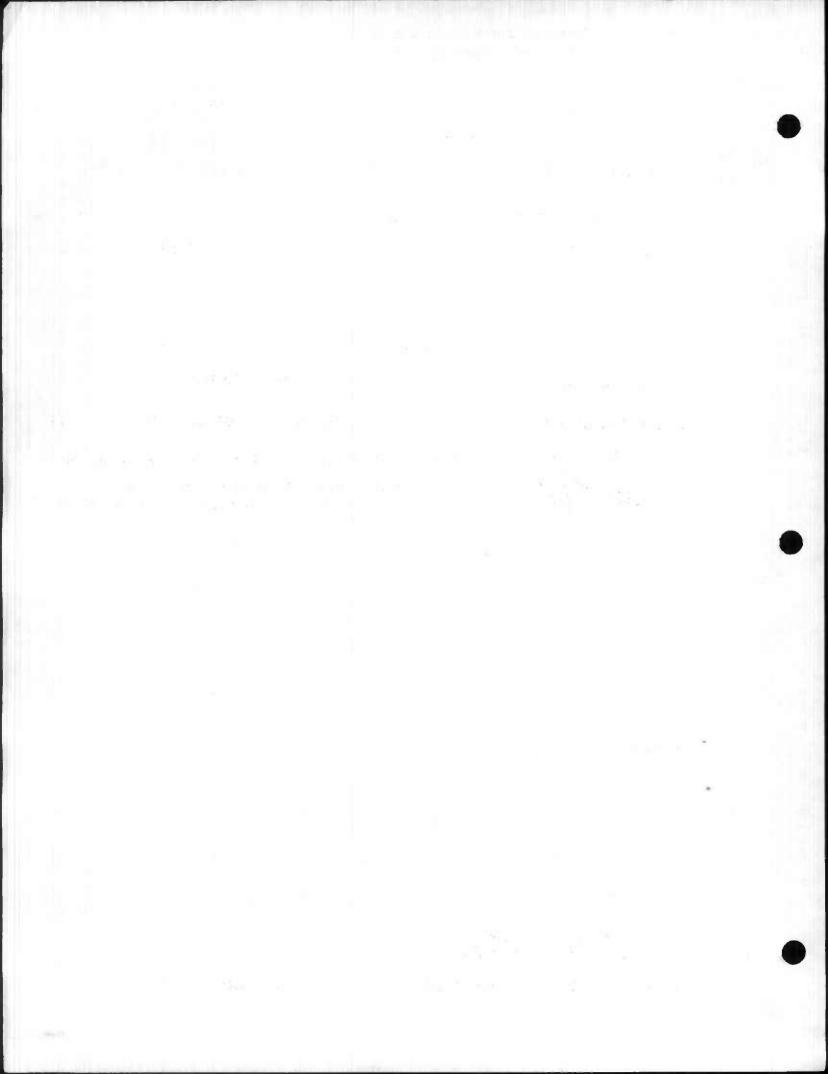
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State of Maryland / Department of Health and Mental Hygiene 00 04108

| | | C. B. C. C. C. C. | | | | Cen | tificate of | Death | | Reg. No. | | | |
|--|-------------------------------|--|--|---|--|--|---|---|---|--|--|-----------------------|--|
| Physici | an | | na (First, Middla, L | | | | | | 2. Data of Da Month | ath Day 20 | | ima of Death | |
| /Medic | | | G. BLYUM | | | | | | | | 00 4 | :50 PM | |
| Examir | er | 10.15 | (If not institution, g | | | | | 4b. City, Town, or | | The state of the s | | | |
| | | MONTGOME | RY HOSPI | CE-CASEY | HOUSE | | | ROCKVIL | LE | MONTG | OMERY | | |
| Funeral Director | | 5. Sociel Security 215.43.8 | | Sex 1 M 2 □ F | 7. Aga (In yrs | . last birthday) 87 Yrs. | If Under 1 Year Months Deys | | | th y, Year) | 9. Birthplaca (S Country) UKRAIN | State or Forei | |
| P | | Usual Rasidence | | | | | | | 220000 | | | | |
| ylan | | 10a. Stata | 10b. County | | 10c. C | ity, Town or Loc | ation | | | | 10d. Ins | sida City Limi | |
| Mar Mar | ō | MD | MONTG | OMERY | R | OCKVILL | E | | | | 1.0 | Yas 201 | |
| th with the Marylan 23a or 28a-f show | I Direc | 10e. Street end No. | umber N AVENUE | | | | 10f. Zip Coda 208. | 50 | | 10g. Citizan of V US ALIE | What Country? IN RESID | ENT | |
| or items | by Funeral Director | | rled 2 Married | 12. Was Dece Armed For 1 ☐ Yas If Yas, Giv Yeer or De | rces? 2 XNo a | | /es Dacedant of Yes, specify Cul □ Yas 2 X No | Hispanic Origin? (Spen, Mexican, Puer | Specify Yas or No to Rican, atc.) | - 14. Rac Blac Specify | ee - Amarican Ind ck, Whita, atc. /: WH | ien, ITE | |
| 72 hours naturel', | Completed | | 15. Decedant's E | Education | | 16a. Deceda | ant's Usual Occu | pation | | 16b. Kind of B | usinass/Industry | | |
| 10 m | plet | | cify only highest g | | | (Giva k | ind of work done O NOT usa retire | during most of wo | rking | | , | | |
| d withir giene. r than | mc | Elamentary/Sec | | Collega (1 | -4or 5+) | MAJOR | | | | RUSS | SIAN ARM | Y | |
| e filed withing the filed withing the filed within the filed went, the filed went, the filed went, the filed went, the filed went, the filed within the filed w | Ŭ | | (First, Middle, Las | it) | | | | 18. Mother's Na | ma (First, Middla, | Maidan Suman | na) | | |
| o de de | Be | | BLYUMIN | - | | | | | "UNKNOW | | ru, | | |
| permit. Pages 1 end 2 should be filed Department of Health end Mentel Hyg Important: If item 27 is marked other any injury or other treumatic event, once. | To | | | | | | | | | | | | |
| 2 sh end is r | | 19a. Informant's N | lame/Ralationship | (Type, Print) | | | | t and Number or R | | | | | |
| end safth safth er tr | | LEONID E | BLYUMIN/S | ON | | 788 P | RINCETO | N PLACE, | ROCKVILI | LE, MARY | LAND 2 | 0850 | |
| Item of He | | 20a. Mathod of Dis | | | | Placa of Dispos | ition (Nema of atory or other ple | ace) | Dete | 20c. Location - | City or Town, St | ata | |
| y or | | 1 Burial 2 | Cramation 3 ☐ 5 ☐ Othar (Spec | □Removal from 5 | otata | | CREMAT | | 02/02/20 | OO ALEXA | NDRTA. | VA | |
| - Line | | | unaral Sarvios Lice | | MI | | Nama end Addr | | 12/02/20 | 00 11111111 | E IDICETTY | | |
| Department International | | 21. Signature of 1 | | | | ED | WARD SA | GEL FUNEI | RAL DIREX | CTION, I | INC. | | |
| 40144 | | 7 | 11/ | 1 | | | | VILLE PI | | | | 20852 | |
| 100 | | 23a. Part1. Entar | tha disaasa, or cor | plicetions that ca | aused tha daa | th. Do not anta | r the mode of dy | ing, such as cardia | c or raspiratory e | rrast, | | oximata al Between | |
| Physician | | snock, or na | art fallura. List only | yona causa on a | s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and proximate interval Between Onset and Death | | | | | | | | |
| /Medical | | Immediata Causa | (Final | | | IDIC | | | | | 2 MC | NITILIC | |
| Examiner | | diseesa or conditi rasulting in daath) | on | a. CANCE | ER OF I | JUNG | | | | | 3 MC | NTHS | |
| | _ | , | | | Dua to (| or as a consequ | nance of): | | | | | | |
| 2 4 | ine in | | _ | , h | | | | | | | 1 | | |
| physician end s the burial-transit | by Physician/Medical Examiner | Sequantially list of | onditions, | D | Dua to (or as a consequence of): | | | | | | | | |
| mirete be executed ng physician end set the bunal-transit | m | Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or Injury c. | | | | | | | | | | | |
| Sick | cai | that initiated avant | S | c. Dua to (or as a consaquance of): | | | | | | | | | |
| ince ig phy es th | 장 | rasulting in daeth) | Last | | 200 10 11 | or as a consaqu | arroe ory. | | | | | | |
| nding use e | 3 | | | d | | | | | | | 1 | | |
| death cer e attendir ed for use | ja | | | | | | | | | | | | |
| the de | 18/0 | Pert II. Other signi | ficant conditions | contributing to de | ath but not ras | sulting in the un- | darlying causa g | ivan in Part I. | 23b. Did | tobacco use co | ntribute to the c | euse of deat | |
| 2 2 2 | P | 2000 | | | | | | | 10 | Yes 2 No | 3 Probably | 4) Unkno | |
| | 7 | COPD | | | | | | | | | | | |
| n sig | | | | | | | | | | an autopsy | 24b. Wara aut | | |
| cete hes been sign, page 2 should be | | CARONAR | Y ARTERY | DISEASE | | | | | perfo | rmed? | eveilable | on of cause | |
| 0 C/V | du | | | | | | | | | | of death? | | |
| pag | ပိ | | | | | | | | 10 | Yes 2 No | 1 Yas | 2□ No | |
| certificate rector, pag | Be | 25. Was casa rafa | rred to madical | | | | | 26. Placa of Da | ath (Check only o | ona) | | | |
| 2 8 6 | 2 | axaminar? | No | Hospital: 1 🗆 Ir | npatiant 2 | ER/Outpatient | 3 DOA O | thar: 4 Nursing I | doma 5 ☐ Rasid | dance 6X10th | ar (Specify)HOS | SPICE | |
| 0 0 | _ | 27. Mannar of Dea | th | | f Injury h, Day Year) | 28b. Tima of | 28c. Inju | | | how Injury occur | | | |
| this aldi | | | | | h, Day Year) | Injury | | ork?]Yas 2∐No | | | | | |
| After fune | | 1 Dylatural | invastigatio | | | | | | 28f Location (| Street and Numb | or or Pum I Pout | | |
| After fune | | 1 □ Natural 2 □ Accidant 3 □ Suicida | invastigation | DR Dlage | a of Injury - At homa, farm, streat, factory, offica ling, atc. (Specify) | | | 28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata) | | | a Alumbar | | |
| After fune | | 2 ☐ Accidant | invastigatio | 28a. Placa | of Injury - At h g, atc. (Speci | fy) | | | City or Tov | vn, Stata) | | a Number, | |
| After | Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Cartifier (Check only) | invastigation 6 Could not be datarmined | buildin | ng, atc. (Speci | fy) wladga, daath | occurred at tha t | ima, data and place | a, and dua to tha | vn, Stata) causa(s) and ma | anner as stated. | - | |
| After fune | edicai Certification: | 2 Accident 3 Suicide 4 Homicide 29e. Certifier | invastigation 6 Could not be datarmined | buildin | best of my knows | fy) wladga, daath | occurred at tha t astigation, in my | ima, data and place opinion, daath occu | a, and dua to tha | vn, Stata) causa(s) and ma | anner as stated. | 7 | |
| within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Cartifier (Check only) | invastigatio | hysician: To the la | best of my knows | fy) wladga, daath | 29c. Licen | opinion, daath occu sa number | a, and dua to tha urred et tha time, | causa(s) and madata end place, | anner as stated, and dua to tha co | ausa(s) | |
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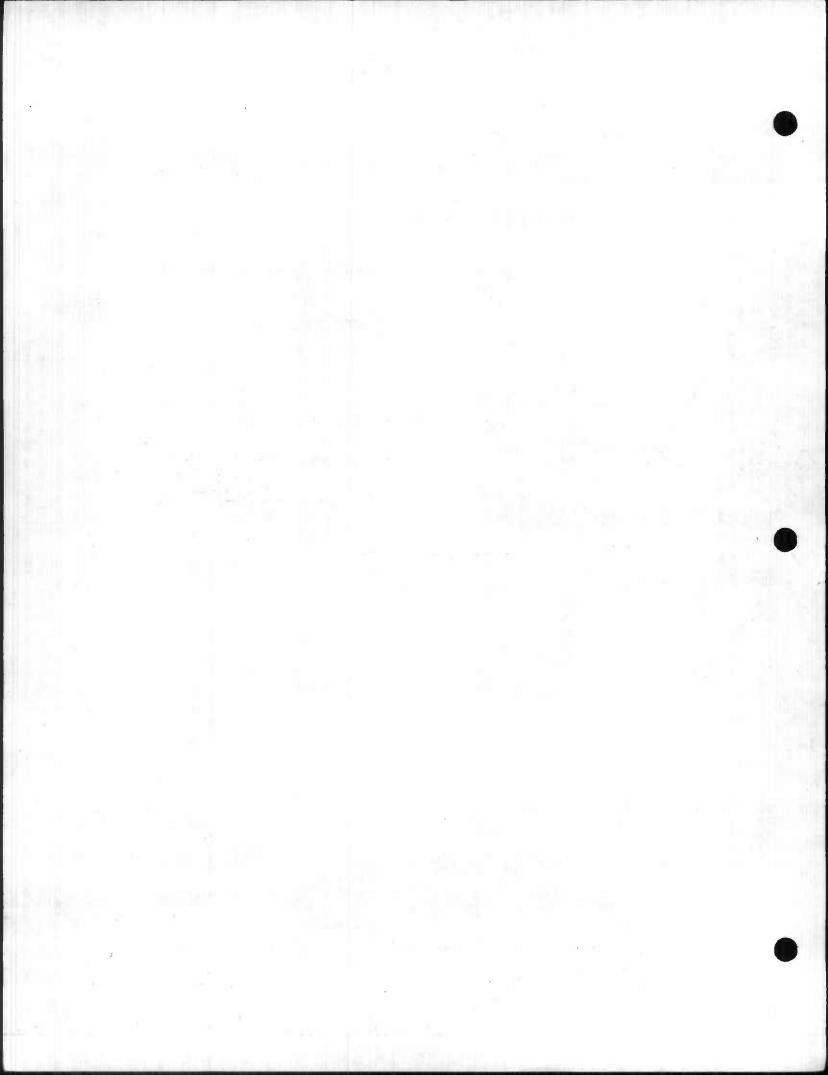


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State of Maryland / Department of Health and Mental Hygiene 00 04 10 9

| | | | | Certificate of | Death | | Reg. No. | | 7705 | |
|--|---|--|--------------------------------------|--|---|---|-------------------------------|----------------|-----------------------------------|--|
| Physician | Decedent's Name (First, Middle, Last) | | | | | | 2. Date of Death Month Day | | 3. Time of Death | |
| Physician /Medical | Daisy D. | Broyer | | | Acres to a | January | | Year 000 | 5:28 PM | |
| Examiner | 4a Facility Name (If not institution, | | | | 4b. City, Town, or Lo | cation of Death | 4c. County | of Death | | |
| | SHADY GROVE A | OVENTIST I | HOSPITA | | ROCKVILI | E | MONT | GOMER | Y | |
| Funeral | 5. Social Security Number | 3. Sex 7. Ag | ge (In yrs. last birth | (ay) If Under 1 Yea | | 8. Date of Birt | h V | 9. Birthplac | e (State or Foreign | |
| Director | 577-36-5018 | 1□ M 2⊠ F | 86 Yr | Months Days | s Hours Min. | (Month, Day, Year) Country) Aug. 02, 1913 Marylar | | | and | |
| v | Usual Residence of Decedent | | | | | | | | | |
| how i | 10a. State 10b. County | | 10c. City, Town o | r Location | | | | 10d | . Inside City Limits | |
| 72 hours after deeth with the Maryland natural, or terms 23s or 28s-f ehow deel Estation must be notified at ted by Funeral Director | Maryland Montgor | nery | Rockvil | le le | | | | | 1 Yes 2 No | |
| | 10e. Street and Number | | 10g. Citizen of | What Country | ? | | | | | |
| | 4713 Arbutus Avenue 20853 | | | | | | USA | 4 | | |
| r Herra 234 Instrument Funeral | 11. Marital Status | 12. Was Decedent | Ever in U,S. | 13. Was Decedent of | Hispanic Origin? (Spe ban, Mexican, Puerto | city Yes or No- | 14. Ra | ce - American | | |
| or the | 1 Never Married 2 Marrie | Armed Forces? d 1 Yes 2 H | No | 1 Yes 2 No | | rucan, etc.) | Specif | ck, White, etc | | |
| d by | 3 ☑ Widowed 4 ☐ Divorced | Year or Dates: | | | орошу. | | Specii | Whit | е | |
| | 15. Decedent's (Specify only highest | | 16a. D | ecedent's Usual Occu | upation e during most of worki | na | 16b. Kind of B | usiness/Indus | stry | |
| Hygiene. There then end, the Me | Elementary/Secondary (0-12) | College (1-4or | 5+) | | e during most of worki ed) | | | | | |
| Ser O | 12 | | | Cashier | | | NIH | VIH VIH | | |
| B VOTE | 17. Father's Name (First, Middle, Li | | | | 18. Mother's Name | | | ne) | | |
| Men de C | Edward L. Dinge | | | | Helen 1 | L. Ship. | Ley | | | |
| and Men aumarke aumarke | 19a. Informant's Name/Relationshi | p (Type, Print) | | | et and Number or Rura | | | | ode) | |
| n 27 | E. J. Boatwrigh | t / Niece | | | St., #200 | | | | 1202 | |
| A Par | 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation ; | DRamoval from State | 20b. Place of D | isposition (Name of crematory or other pl | lace) | Date | 20c. Location | - City or Town | , State | |
| nant of I | 4 Donation 5 Other (Spe | | Norbeck | Memorial | Park 02 | /04/00 | Olney, | Maryla | and | |
| Departu Importa eny Inju | 21. Signature of Funeral Service Li | censee | | 22. Name and Add | ress of Facility Hine | es-Rina | ldi Fun | eral H | ome | |
| ong ony ony | 00-1 | James O | 0 | 11800 Nev | v Hampshire | Avenu | | | | |
| | 23a. Part1. Enter the disease, or shock, or heart failure. List | omplications that cause | the death. Do not | enter the mode of dy | oring, Mary | r respiratory ar | 20904 rest, | A | pproximate | |
| nysician | shock, or heart failure. List or | nly one cause on each li | ne. | | | | | In O | terval Between nset and Death | |
| /Medical | Immediate Cause (Final disease or condition | | | | | | | | | |
| xaminer | disease or condition resulting in death) | aACUL | | | | | | | nknown | |
| 5 | | A | Due to (or as a co | | | | | TT. | nknown | |
| e attending physicien and bd for use as the burial-transit sician/Medical Examir | | b. Acute | e arrhyth | | | | | | IIKIIOWII | |
| n and tel-transit Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or as a cor | isequence oi). | | | | | | |
| physicien and s the burlat-transit sdical Examir | Cause (Disease or injury that initiated events | C | c. Due to (or as a consequence of): | | | | | | | |
| 73.6 | resulting in death) Last | | Due to (or as a cor | isequalice (i). | | | | | | |
| for use | | d | | | | | | | | |
| attendir of for use | Det II Other desificant and file | | | | the to Boat | l age pt-de | | | | |
| | Part II. Other significant condition | s contributing to death o | ut not resulting in the | e underlying cause g | iven in Part I. | | | | ne cause of death? | |
| igned be deter | | | | | | יטי | Tes 2□ No | 3 Probat | bly 40 Unknow | |
| ss been signed by the 2 should be deteched in pieted by Phys | | | | | | 24a. Was | an autopsy | 24b. Were | autopsy findings | |
| should should | | | | | | | med? | comp | ible prior to eletion of cause | |
| - A E | | | | | | | | of de | | |
| Com | | | | | | 101 | res 2 No | 1 DY | res 2□ No | |
| this certificate ral director, pag TO Be Co | 25. Was case referred to medical examiner? | Moonital | | 10 | 26. Place of Death | (Check only o | ne) | | | |
| 물을 다 | 1 Yes 2 No | Hospital: 1 Inpatie | 45 | itient 3LI DOA | ther: 4 Nursing Ho | | | | | |
| . 5 9 5 | 27. Manner of Death 1 ⊠ Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | y Year) 28b. Tim y Year) Inju | ry W | | 28d. Describe h | now injury occur | rred | | |
| Within 24 hours start death. To the Funeral Director: After to completely filled in by the funeral Medical Certification: | 2 Accident investiga 3 Suicide 6 Could no | the | | | Yes 2 No | | | | | |
| fraci n by | 4 Homicide determin | ari 288. Place of in | | | | | | | | |
| E E | | | | | | | | | | |
| n 24 hou ve Funer pletely fill edical | | Physician: To the best aminer: On the basis of | | | | | | | | |
| the plet | ane) | and manner at | | | | | | | | |
| T C C C C C C C C C C C C C C C C C C C | 29b. Signature and title of certifier | 7 | 29c. License number | | | | 29d. Date signe | | | |
| 1 | Jugar | la to | × > \ | //() | 2:10 fo | | Janua | ru 28 | 2000 | |
| 13 | 30. Name and address of person wi | no completed cause of o | leath (Item 23a) (Ty | pe, Print) | | | | - 0 | 1 | |
| | Or lee Pante | 6\ 990 r | Modica. | Center | Div. Fo | (KUIL | -mi | 20 | 750 | |
| State | 31. Date filed (Month, Day, Year) | 32. Registr | ar's Signature | 7110 | 0,0 | | | | 0 | |

State Registrar



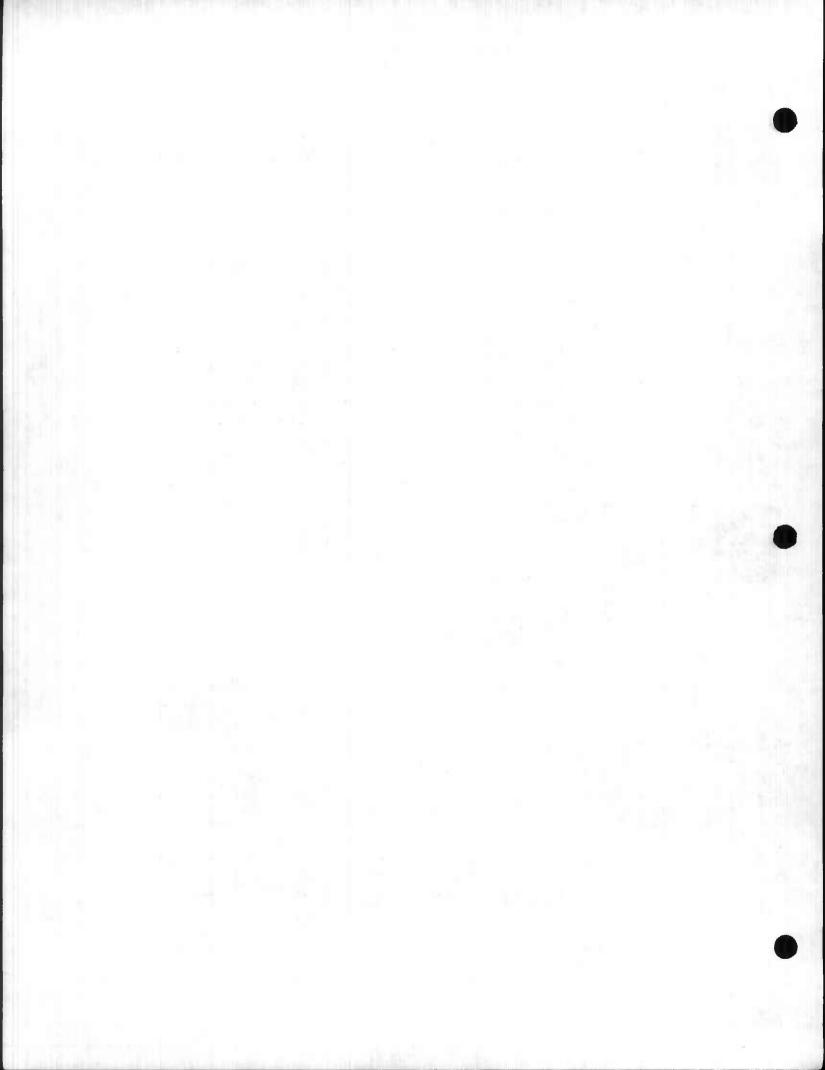
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle I ast) 2. Date of Death 3. Time of Death Day Month Year **Physician** Irma Mae Braisted January 29, 2000 9:50AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 750 College Parkway Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country)
October 20, 1926 Massachusetts 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 ☑ F Ves 73 Director 014-26-5162 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yas 2 □ No 28e-f 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 급 must be r 750 College Parkway 20850 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or herra 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status I/d be filed within 72 hours after de tental Hygiene. 'sad other than "natural", or flams Ic event, the Medical Examiner or 1 Never Married 2™ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 21215-0020 Specity: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H antt if them 27 is marked oth lury or other trainmatic even Be Berton L. Blanchard Martha D. Poulson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband 750 College Parkway, Rockville, Maryland 20850 Frank Alfred Braisted, Jr./ 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 3 20a. Method of Disposition 20c. Location - City or Town, Stete Feb. 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 200Ó Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 11e, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 23a. Party Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Cardiac Arrythmia minutes disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Coronary Heart Disease attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension Box 68760, Due to (or as a consequence of): P.0. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, ģ 24b. Wara autopsy tindings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate has Dege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 XYes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 (XNatural 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Illed in by 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di compiataly filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier (Un derman un D06333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Lindeman, M.D. 10215 Fernwood Road, #100, Bethesda, Maryland 20817-1106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 2000 Registrar

DHMH 16 Rev 6/95



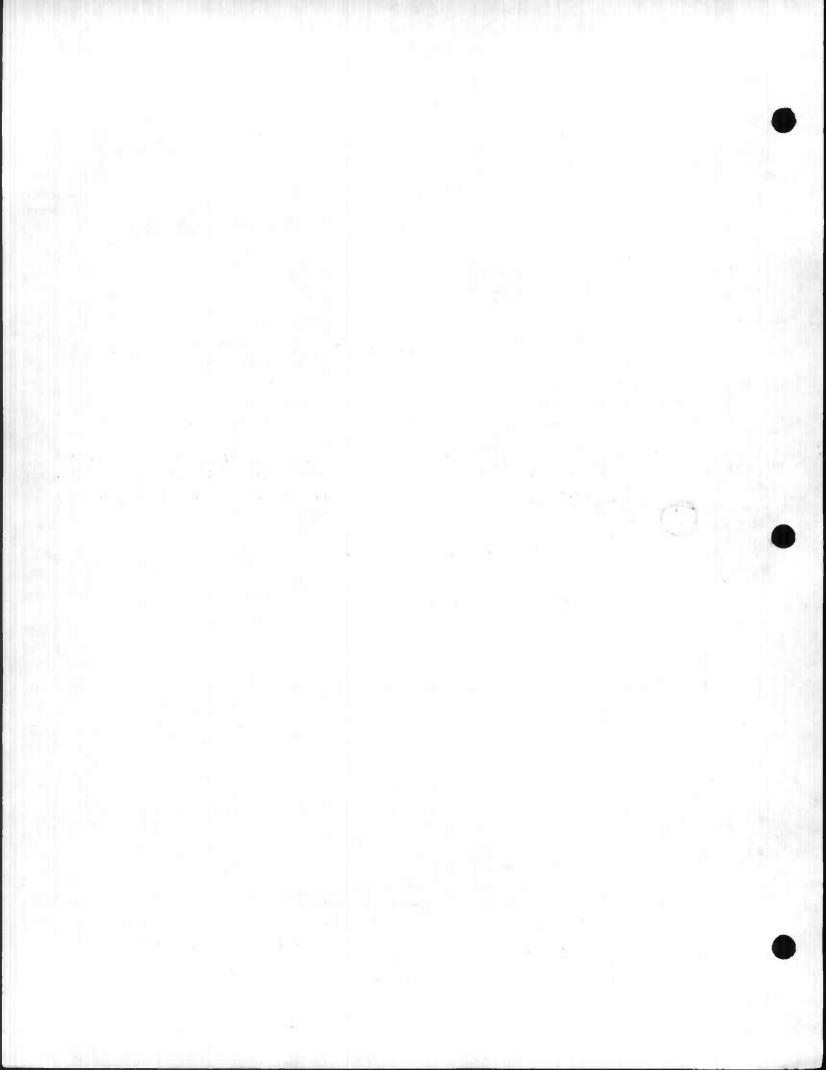
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:30PM Charles January 2000 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 5552 Norbeck Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (tn yrs. last birthday) **Funeral** 12 M 2□ F Months Days Yrs. Aug. 28,1919 80 579-32-1131 Director Texas Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director MD Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States of 8912 Ridge Place 20817 America

14. Race - American Indian Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 25 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: P White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Management Engineer U.S. Government permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: If frem 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Brewer Mary Spann 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary O. Brewer/Spouse 8912 Ridge Place Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Suriel 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/29/00 Brentwood, Maryland 21. Signature of Funeral Service Donne 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New HAmpshire Ave. Silver Spring, MD 20904 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in one cause on each line. Physician /Medical Immediate Cause (Fil Atheroscleration Heart Disease 10 years disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician a Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Renal Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Souther (Specify) dig 14511 P 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Maturel 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) 29b. Signature end the of optide 29c. License number 29d. Date signed (Month, Day, Year) 035103 January 21, 2000 MD 36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6240 mon trose Rel Rockville no 20852 Stephen Vaccare 33 x 31. Date filed (Month, Day, Year)

JAN 3 1 2000 32. BogIstrar's Signature State souls Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 44 12 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Month **Physician** Allen Miller Brown 25 2000 Jan. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 4545 Linthicum Road Howard Dayton 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 579-10-3654 1 XM 2 F 82 Yrs June 2 1917 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Dayton Md Howard 1 Yes 2 XNo Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21036 USA 4545 Linthicum Road Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 11. Maritai Status 1 ☐ Yes 2 No if Yes, Give Yaar or Dates: 1 Never Married 2 Married Specify: white 1 Yes 2X No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Peges 1 and 2 should be file Department of Health end Mentel Hy Important: if Item 27 is marked oth any Injury or other traumatic event DOSB. John Harris Brown Annie P. Lisher 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4545 Linthicum Rd., Dayton, Md 21036 19a. Informant's Name/Ralationship (Type, Print) Estelle Brown (spouse) 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation Serv 1-28-2000 Sykesville, Md 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility Haight Funeral Home & Chapel 21. Signature of Funaral Service Licensea Drian P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Onset and Death Physician /Medical Immediate Cause (Final ISCHÉMIC HART disaase or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner ettending physicien end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 No 3 Probably 4 Unknown ADUST ONSET DIABLES MENTIL by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed states ADRING STENDSIN page 1 ☐ Yes 2 No 1 ☐ Yes 2 Ho CARDIONY SATTY To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; p. 25. Was cese referred to medical axaminar? Be 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 PARasidance 6 □Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending Investigation 1 ☐ Yas 2 ☐ No a 24 hours after death.

Francisco Strate of the first of 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Sulcide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifian 29d. Data signed (Month, Day, Year)

State Registrar

30. Nama and addrage of pe

Throad mo 31. Date filed (Month, Day, Year) JAN 3 1 2000

32. Registrar's Signature 30 peros

o completed cause of daath (Itam 23a) (Type, Print)

3416 ONMINUM COURT

SUITE LOO, BLIFE mo 2083L

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of filed within 72 hours efter of Hygiene.

The law requires that the death certificate be executed

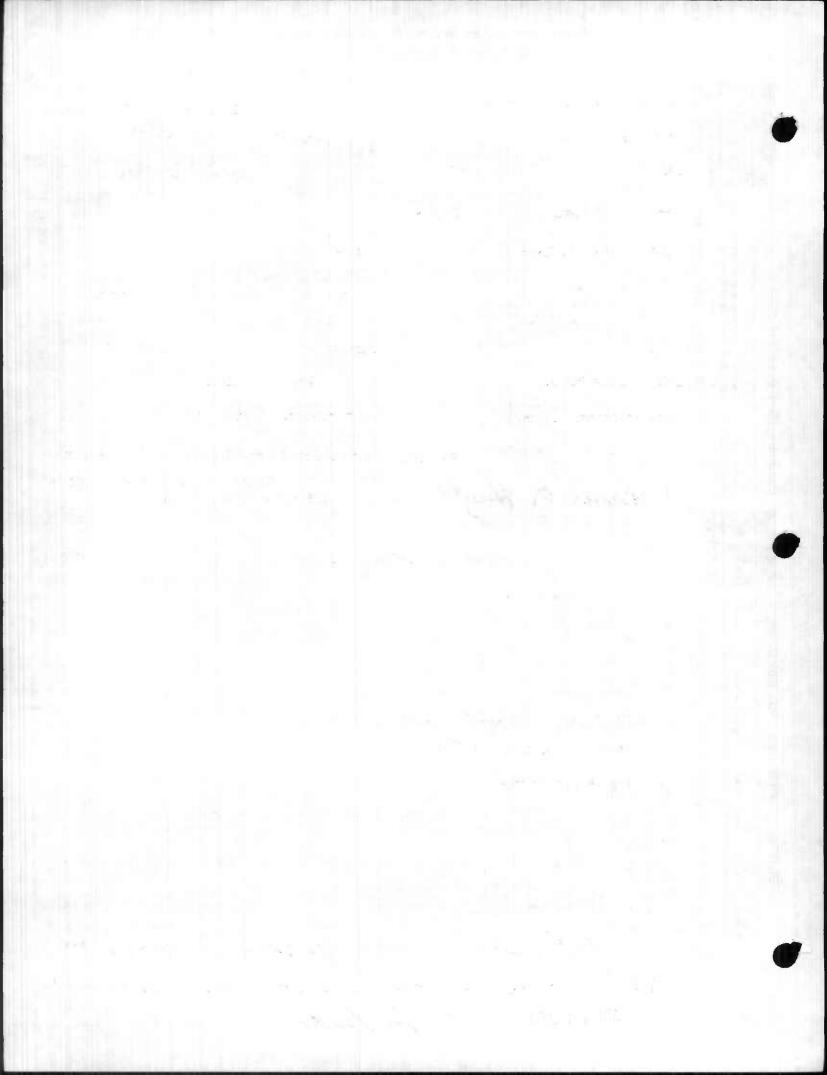
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After this certificate

Box 68760.

P.O.

Division of Vital Records,



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death v

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other then "natural", or item

permit. Pages 1 and 2 should be file Deperturant of Health and Mental Hy Important: if Itam 27 is marked oth any Injury or other traumatic avant BOBS.

Physician /Medical

Examiner

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To the Hospital or Attanding Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Examiner

Physician/Medicai

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Completed

8

edical Certification: To

Baltimore, Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

AARON BRAY BIXLER

1. Decedent's Name (First, Middle, Last)

AMEND ITEMS: #23 PART I. 27 PER MEO

4s Facility Name (If not institution, give street and number)

2. Date of Death 3. Time of Death FEBRUARY 6,2000

3203 HERNWOOD ROAD

4b. City, Town, or Location of Death WOODSTOCK

3:30P.M. 4c. County of Death

04413

1 Yes 2 No

Funeral Director

r than "natural", or items 23s or 28s-f ahow the Madical Examiner must be notified at

Director

Funeral

P

Completed

8

213-46-4218 10s. State 10b. County

HOM 20F Yrs. 50

7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. | Days

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) January 9, 1950 Pennsylvania

Usual Residence of Decedent

5. Social Security Number

Baltimore

10c. City, Town or Location

10d. Inside City Limits

BALTIMORE

Maryland 10e. Street and Number Woodstock 10f. Zip Code

10g. Citizen of What Country?

16b. Kind of Business/Industry

3203 Hernwood Road

11 Marital Status 1 Never Married 2/CkMerried 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give

United States 21163 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2√ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify:

White

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

Year or Dates:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Consultant

Finances/Investments

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

Erma Maxine Otto

18. Mother's Name (First, Middle, Maiden Surname)

2/10

Guy Sterling Bixler, Sr.

19a. Informant's Neme/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Terrie A. Bixler, wife 20a. Method of Disposition ts Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

3203 Hernwood Rd, Woodstock,
20b. Place of Disposition (Name of Cametery, cremetory or other place)

2/10 Bixler's U.M. Church Cemetery

MD 21163 20c. Location - City or Town, State Westminster, MD

21. Signature of Funeral Service Licensee

22. Name end Address of Facility

91 Willis Street

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Westminster, MD

21157 Approximate Intervel Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

2 No

24b. Wara autopsy findings available prior to completion of cause of death?

2 No

25. Was case referred to medical examiner? 1∑Yes 2□ No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 NResidence 6 Other (Specify)

1 Wes

28d. Describe how injury occurred

27. Mapner of Death 1 Netural 2 Accident 3 Suicide

4 \(\Pi\) Homicide

5 Pending investigation 6 Could not be

28b. Time of 28c. Injury at Work? Injury 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stele)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contilio an

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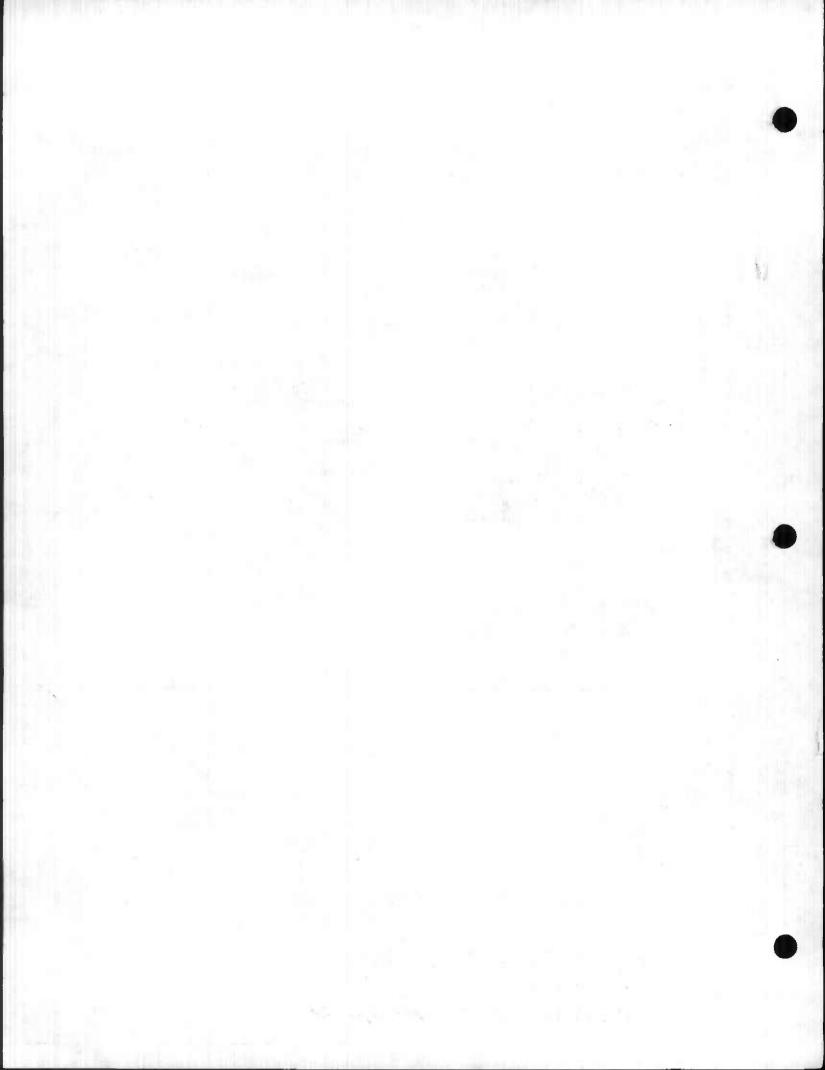
29c. License number O.C.M.E. 29d. Dete signed (Month, Day, Year) FEBRUARY 7,2000

Cabse of death (ftern 23a) (Type, Print) estaner

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Day, Year) FEB 0 9 2000 32. Registrar's Signature Comment of the state of the sta



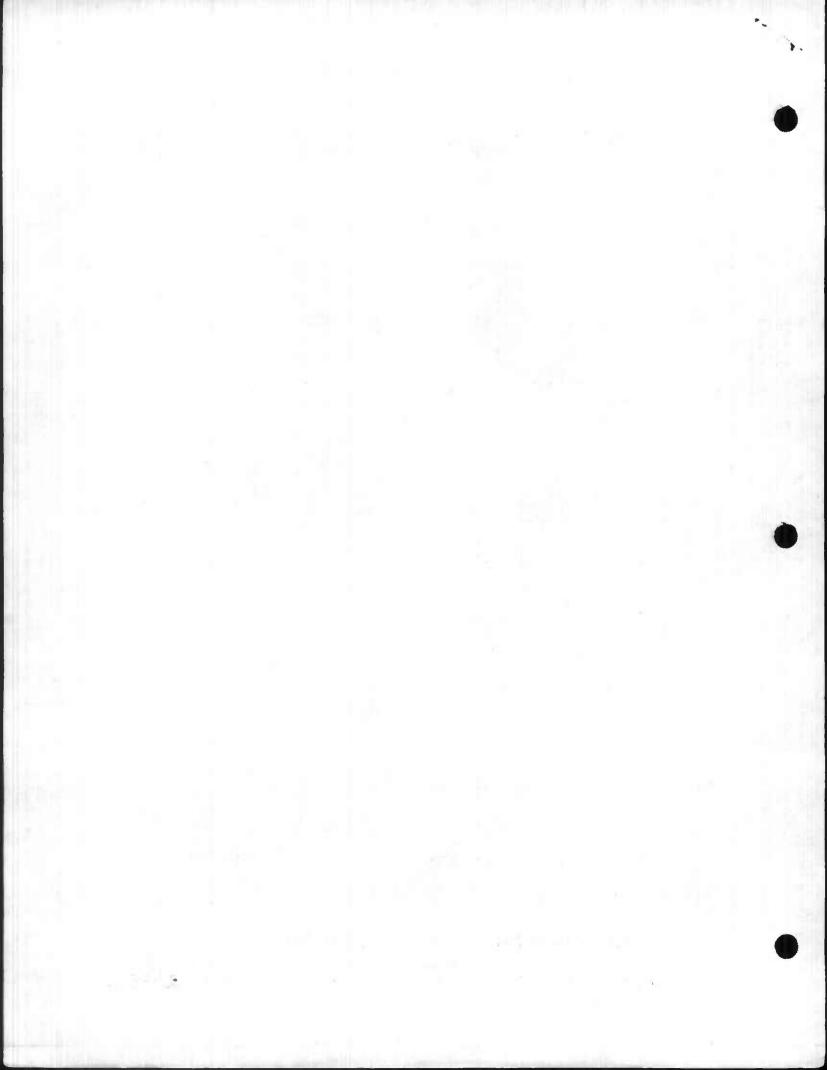
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06614 Amend #17,2/3/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Harold P. Brocksmith January 28, 2000 7:15 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 12 M 2□ F Deys Hours Yrs. 93 216-44-7591 Director November 11,1906 Missouri Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 4513 North Chelsea Lane 20814 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Rece - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 X Married b Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant if Nem 27 is marked other than "nati Elementery/Secondery (0-12) College (1-4or 5+) Accountant Federal Government 17. Fether's Neme (First_Middle_Last)
Brocksmith
Arnold Broadsmith 18. Mother's Name (First, Middle, Maiden Sumeme) Be Emma Phillips 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health Important: If Nem 27 Edith S. Brocksmith/Wife 4513 North Chelsea Lane, Bethesda, Maryland 20814 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Burial 2 □ Cremetion 3 □ Removel from Stete February Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 2, 2000 Rockville, Maryland Signeture of Furieral Service Lig 22. Neme end Address of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Perf. Enter the disease, or combinations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Pulmonary Edema 12Hours diseese or condition resulting in deeth) **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Congestive Heart Failure 5Years The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last the burial-trar Due to (or as e consequence of) Hypertension 10Years Division of Vital Records, P.O. Box 68760 Due to (or es a consequence of): Coronary Artery Disease 5Years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tas 2 No 3 Probably 4 No Unknown Dehydration þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ₺ Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of tnjury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding Investigation 1 X Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide after To the Hospital within 24 hours a To the Funeral Completely filled 1KC Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medicat Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Allatham ML D0053615 January 28, 2000 20 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) Avuna Nathan 121 Congressional lane, Rockville MD 20852 31. Dete filed (Month, Dey, Year) FEB 1 32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar

larade Brocksmith



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04415 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death 9.35 AL MARY ELIZABETH BROOKS JANUARY 27 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death CARRIAGE HILL - BETHESDA MONTGOMERY BETHESDA If Under 1 Year 8. Data of Birth (Month, Day, Year) Oct. 1, 19 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖺 F 77 Yrs. 384-46-0724 Michigan Usuai Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5215 W. Cedar Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) Clark David Brooks Sallie Wier 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Butcher/Niece 10401 Bridle Lane, Potomac, Maryland 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Data cemetary, crematory or other place) 1 Burial 2 □ Cramation 3 □ Ramoval Irom Stete Feb. Woodlawn Cemetery Detroit, Michigan 4 ☐ Donation 5 ☐ Othar (Specify) 2000 21. Signature of Funeral Service Licensee Robert A. Humphrey Funeral Home/Bethesda-Chevy M00198 Rethesda, Maryland 20814-3501 23a. Part1. Enter ha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Careinoma Immediata Ceuse (Finel disaasa or condition rasulting in death) oronary Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) YILL Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 1 Unknown 1 Yes 2 No Schaeun 24b. Were autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rel', or frame 23a or 28a-f ahow Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hydjone. Important: If fem 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Essentia

altimore, Maryland 21215-0020

Box 68760

o.

Records.

Vital

this

After

24 hours after death.

To the Hosp within 24 hor To the Fune completely fi

ID

filled in by

Division of

or Attending

Director

Funeral

Completed

Be

0

physician and the burial-transit 95 page 2 funeral

Examiner Physician/Medical þ Completed Be Certification: To Medical 29a. Certifier

25. Was casa referred to medical axaminar?

1 Yes 2 1 No

completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Hospitai: 1 ☐ Inpatient 28a. Data ol Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28a. Plece of Injury - At homa, larm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

1 Yes 2 No

4 Homicide

(Check only

29c. License number 0047330 29d. Date signed (Month, Day, Year)

Thomas Joseph, M.D. # 207. ROCKVILLE, MD 20852 30. Nama and address of person who complated causa of death ((tern 23a) (Type, Print) .# 207. DMONSTON DR

State

31. Date filed (Month, Day, Year) FEB 1

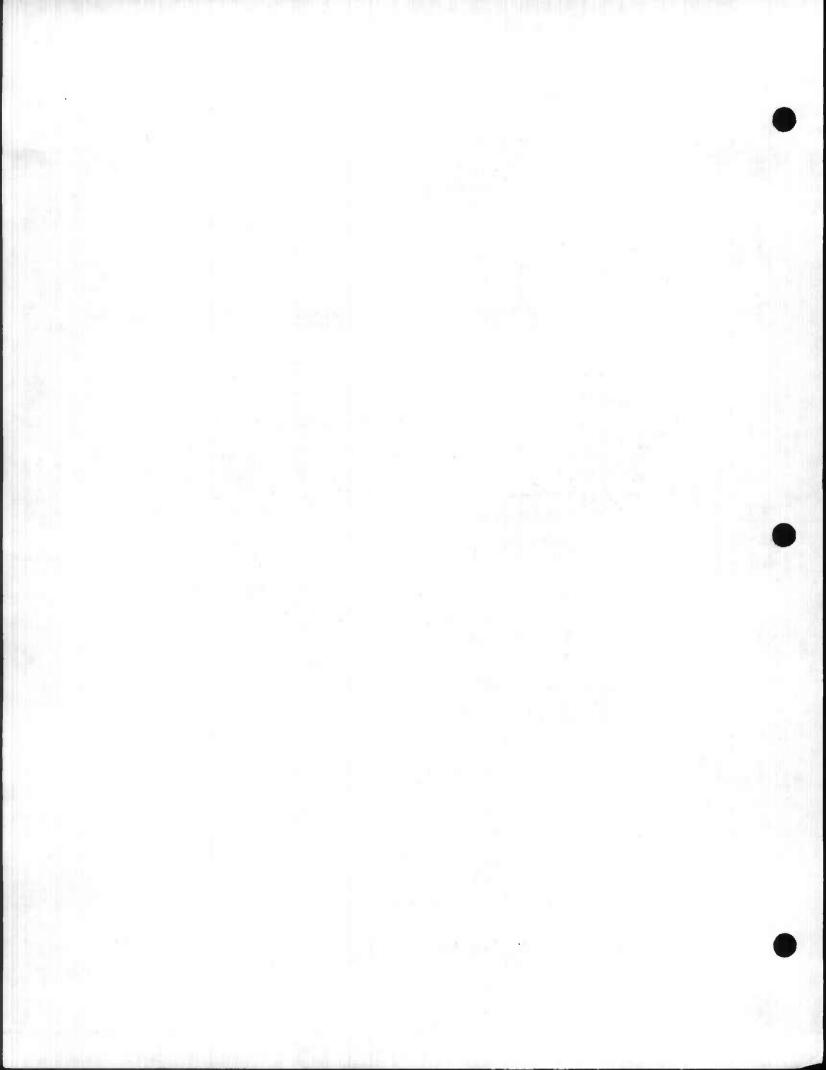
Trous

32. Registrar's Signature

V - 10 Jens

Registrar

2 ER/Outpatient 3 DOA



| D 00-0566-01 | 3 Please | Type or Prin | | | | c. Assure A | | | ble. | |
|---|---|---|---|--|-------------------------|--|--|--------------------------------|-----------------------------------|---|
| EBBERT BECK | | State of Ivia | aryland / | Certifica | | | | Reg. No. | n or | s ls 16 |
| | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Dete of De | eth | | Time of Death |
| Physician /Medical | Ebbert Lindsa | ay Beck | | | | | JANUAR | Y 31,20 | Year 000 6 | :25P.M. |
| Examiner | 4e Fecility Neme (If not institution, giv | e street and number) | | | | 4b. City, Town, or | Location of Deet | | | |
| SVL - | 405 CENTER STREET | | | | | MT.AIRY | | CARRO | LL | |
| Funeral Director | 219-14-7820 | Sex 7. Age | e (In yrs. last 74 | birthday) If Und Yrs. Month | der 1 Yea s Days | | | v. Year) | 9. Birthplace Country) Mary | (State or Foreign Land |
| show show | Usuel Residence of Decedent 10a. State 10b. County Maryland Carroll | | 10c. City, To | own or Location | | | | | | Inside City Limits |
| or 28a-fs | | | rit. | - | Zin Cada | | | 10g. Citizen of V | | |
| Dir | 10e. Street and Number | | | 107. | Zip Code | 71 | | | | |
| m 23 | 405 Center Stree | 12. Was Decedent 8 | Ever in IIS | 13 Was De | 217 | | Specify Yes or No | | States e - American Ir | |
| 15-0020 72 hours after death with the Manyland **natural*, or from 23a or 28a-f show entire Exemple motified at leted by Funeral Director | 1 ☐ Never Merried 2 ☒ Married | Armed Forces? 1 ⊠ Yes 2 □ N If Yas, Give Year or Dates: | | | | Hispanic Origin? (s ben, Mexican, Pue Specify: | rto Rican, etc.) | Specify | ok, White, etc. | |
| 5-0020 72 hours at natural, or natural or natural early learn steel by I | 15. Decedent's Ed | | 11 | Sa. Decedent's U | sual Occi | upation | | 16b. Kind of Bu | | |
| 215 215 8n m | (Specify only highest gra Elemantary/Secondary (0-12) | ede completed) College (1-4or 5 | 4) | (Give kind of life. DO NO) | work don use retir | e during most of wo | orking | | | 1975 |
| d within giene. | 12th | College (1-4015 | +) | Self- | emp1 | oyed | | Fa | rmer | |
| Maryland 21215-0 d 2 should be filed within 72 ho th and Mental Hygiene. 7 is marked other than *nature traumatic event, fre Medical To Be Completed | 17. Father's Name (First, Middle, Last, Herman S. Beck, | | | | | | ame (First, Middle A Marie I | | ne) | |
| M dd 2 | 19e. Informant's Neme/Ralationship (Ellen Louise Becl | | | | | et and Number or F | | | | |
| s 1 and 3 the alth them 27 other tr | 20a. Method of Disposition | | 20b. Place | of Disposition (/ | Vama of | in and | Date | 20c. Location - | City or Town, | State |
| S age | 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | | Grove C | | | 2/5/2000 | Mt. | Airy, M | Maryland |
| Baltimore, pemit. Pages 1 at Department of Hea Important: If Hem any Injury or othe | 21. Signature of Juneral Service Licer | | yed | Burri | er-Q | ress of Fecility ueen Fund 1d Libert | | | | 21784 |
| P.O. Box 68760, at the death certificate be associed by the attending physician and letached for use as the burial-fransit by sician/Medical Examiner | Immediate Cause (Final disease or composition of yeart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted evants rasulting in death) Last | Arterioso | cleroti Due to (or as Dua to (or as | | ovase | | | rrest, | Inte | proximate erval Between set and Death |
| | Pert II. Other significant conditions of CHRONIC RENAL FAI | | ut not resulting | g in the underlyin | g cause (| iven in Part I. | | tobacco uss co Yas 2 No | | cause of death |
| w requires to been sign should be | | | | | | | perfe | an autopsy ormed? CTION | evailab | sutopsy findings ble prior to elion of cause th? |
| | | | | | | | 10 | Yes 25No | 1 □ Ye | es 2 No |
| Iclan: Ticlan: Ticlan: Tector, p. Be C. | 25. Was case rafarred to medical | | | | | 26. Place of De | eath (Check only | 41 | | |
| hysici nis cer il direc | examinar? 1 Yes 2 No | Hospital: 1 Inpatie | nt 2 ER/ | Outpatient 3 | DOA | thar: 4 Nursing | Home 5 TRes | idenca 6 □Oth | ner (Specify) | |
| 0 | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injui (Month, Da) | Year) 28 | b. Time of Injury M | 28c. In W | ury at ork? □ Yes 2 □ No | 9 Home 5 DAResidenca 6 □ Other (Specify) 28d. Describe how injury occurred | | | |
| DIVISION C ball or Attending P is after death. al Director: After t led in by the funera Certification: | 3 Suicide 6 Could not b 4 Homicide detarmined | | | | | 8 | 28f. Location (Street and Number or Rural Route Number City or Town, State) | | | oute Number, |
| Hospi 14 hour Funer tely fill | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar | ysician: To the best of niner: On the basis of and manner sta | examination | iga, daath occurr and/or invastigat | ed at the ion, in my | tima, date and place opinion, daath occ | ce, and dua to the curred at tha time, | causa(s) and madate and placa, | annar as stated and dua to the | d. a csusa(s) |
| within To the compla | 29b. Signature and title of certifier | , | | | 29c. Lice | nsa number | | 29d. Date signe | d (Month, Day | , Year) |

State Registrar

FEB 0 2 2000

THE POPE M. King.

31. Date filed (Month, Day, Year)

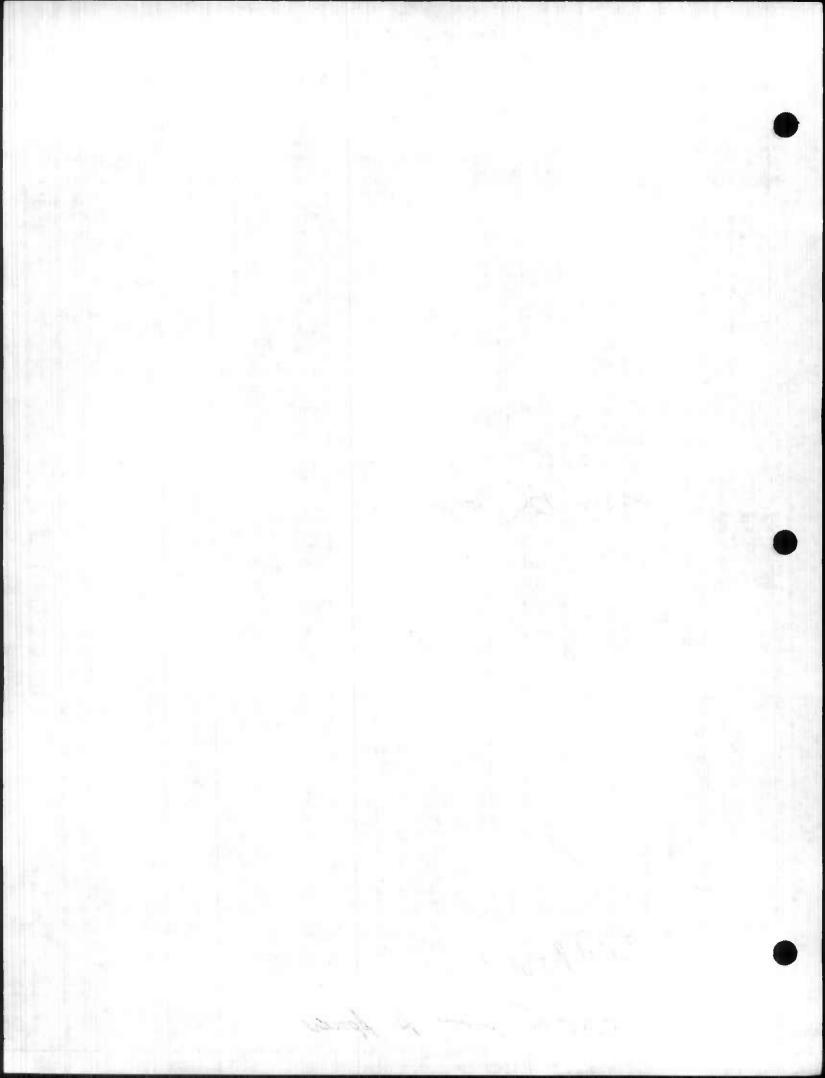
32. Registrar's Signeture

30. Name and address of parson who compared cause of death (Item 23a) (Type, Print)

O.C.M.E.

FEBRUARY 1,2000

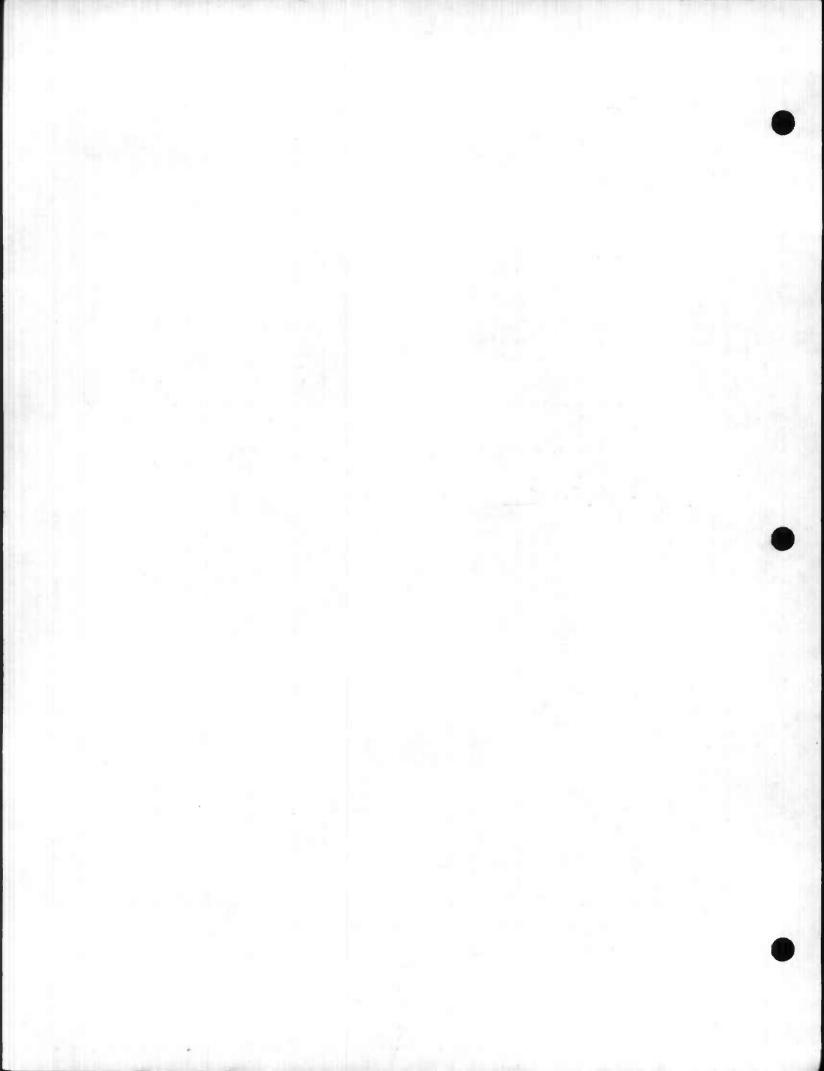
111 Penn Street, Baltimore, Maryland 21201



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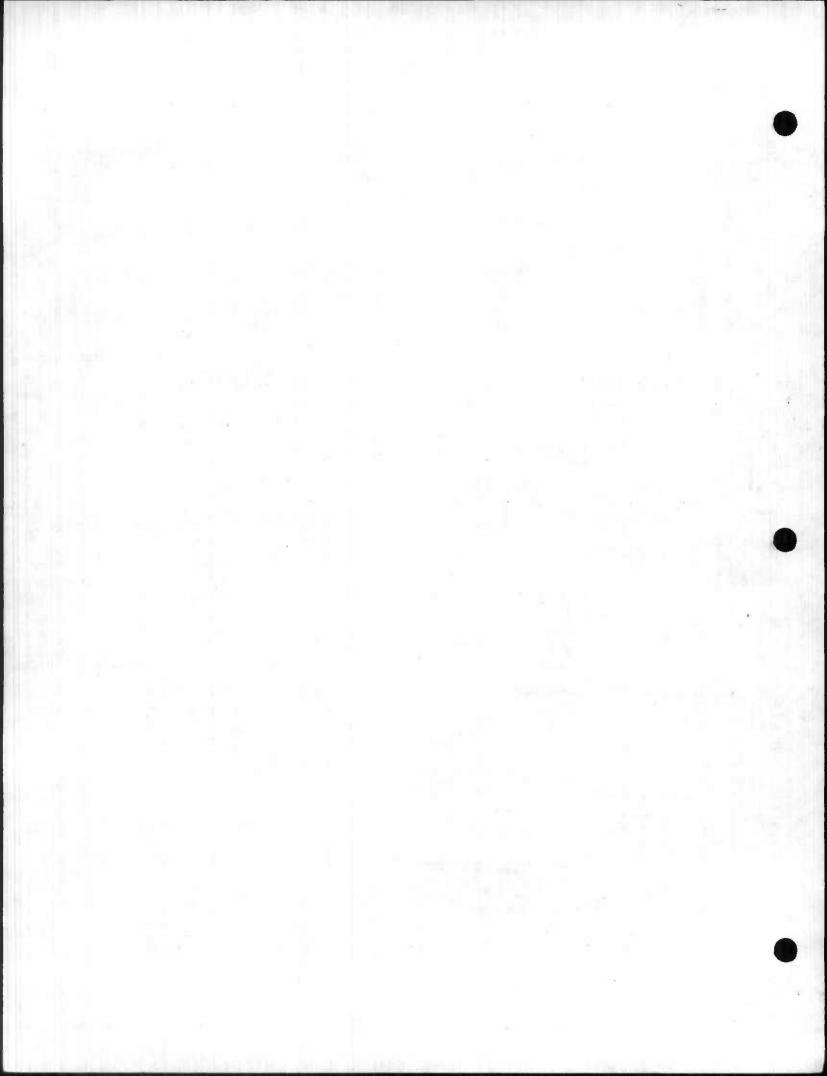
Registrar

FEB 0 2 2000



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death | | Reg. No. | 04418 | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| | 1. Decedent's Name (First, Middle, Last) | 2. Date of D Month | eath Day Yea | 3. Tima of Death | | | | | |
| ician dical | JULIUS CHARLES BYRD | JANUAR | | | | | | | |
| niner | 4a Facility Name (If not institution, give street and number) 4b. City, Total | wn, or Location of Dea | th 4c. County of D | eath | | | | | |
| | | IA PARK | MONTGOM | IERY | | | | | |
| | 5. Social Security Number 250 64 8293 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Wonths Days Hours | 24 Hrs. 6. Date of Bi (Month, D JULY 1 | orth (9.18) (1941) (1955) (1941) (1955) | Birthplace (State or Foreign Country) OUTH CAROLIN | | | | | |
| _ | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits | | | | | |
| Directo | MD PRINCE GEORGE'S ADELPHI | | | | | | | | |
| | 10e. Street and Number 10f. Zip Code 2309 METZEROTT ROAD 20783 | | 10g. Citizen of What USA | Country? | | | | | |
| by runeral | 11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No 1961 If Yes, Give Year or Dates: 1963 | | o- 14. Race - A Black, W Specify: | merican Indian, thite, etc. WHITE | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most | t of working | 16b. Kind of Busine | | | | | | |
| Mental Hygiene. srked other than "naturation effice event, the Medical. To Be Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) 2 POSTAL UNION PRESID N.A.L.C. #2611 | ENT | UNITED ST SERV | ATES POSTAL | | | | | |
| | 17. Father's Name (First, Middle, Last) 18. Mothe | or's Name (First, Middle CLLE E. BRY | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number | er or Rural Route Num | ber, City or Town, Stat | e, Zip Code) | | | | | |
| | GENE BYRD (BROTHER) 143 SANDY HAVEN DR | IVE ELGIN, | SC 29045 | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) FORM LINCOLN CREMATORY | Date 2-1-2000 | 20c. Location - City BRENTWOOD | | | | | | |
| , | 21. Signature of Füheral Service Licensee 22. Name and Address of Facility III AVENUE SILVER | | | EW HAMPSHIRE 0904 | | | | | |
| ٠ | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only ope cause on each line. | | | | | | | | |
| | snock, or near tailure. List only ope cause on each line. | | | Approximata Intervat Between Onset and Death | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. A Cute Respiratory f | Foilure | | 1 month | | | | | |
| | | | | 1 | | | | | |
| 5 | Chronic Obstructive | Lung Dis | ease | 10 years | | | | | |
| Fydillia | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |) | | | | | | | |
| Medical | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 200 | d | | | | | | | | |
| Dy rilyeleigher | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | , | ute to the cause of death? Probably 4 Unknown | | | | | |
| Completed by | | | s an autopsy 24 formed? | lb. Were autopsy findings available prior to completion of cause of death? | | | | | |
| 1 | | 10 | Yes 200 | 1 ☐ Yes 2NNo | | | | | |
| | 25. Was case referred to medical 26. Place | | | 13 165 254 110 | | | | | |
| 0 | examiner? Mosnital: | of Death (Check only | | Sanath A | | | | | |
| tion: To | 27. Manner of Death Natural 5 Pending Investigation 2 Accident 2 Revolute 2 Revolute 3 DoA 3 DoA 4 New New | 11-11-11 | how injury occurred | респу) | | | | | |
| Certification | 3 Suicide 4 Homicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location City or To | ion (Street and Number or Rural Route Number, r Town, State) | | | | | | |
| edical C | 29a. Certifier (Check only one) 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated. | | | | | | | | |
| M | 29b. Signature and title of certifier | | 29d. Date signed (M | onth, Day, Year) | | | | | |
| | DI258 | 2 | January " | 29,2000 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALFRED MUNZER 7600 CARROLL AVE. TAKOMA PARK, MD 209 | 912 | | | | | | | |
| ate | 31. Date filed (Month, Day, Year) JAN 3 1 2000 32. Registrar's Signature 4. Apartal | | | | | | | | |
| ar 🗀 | JAIN OIL COULD D. Sports | | | | | | | | |



| | Physician /Medical Examiner | |
|---|-----------------------------------|--|
| ľ | Funeral Director | |

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 28 2000 2:30 PM Gerald C. Brabham Jan 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1810 Gillis Rd. Woodbine Carroll If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 118 M 2□ F Months 218-32-0682 65 Oct 13, 1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Interpretation of Health and Mental Hyglene. Interpretation 11 fem 23e or 28e-f show interpretation 22 expected other than "naturel", or fems 23e or 28e-f show many miny or other traumatic event, as Mentale Experiment and the notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of Whai Country? 21797 United States Funeral 1810 Gillis Rd. 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedeni Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1Æ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1954-Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1958 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12th Sun Papers The Baltimore Sun 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William V. Brabham Blanche Violet Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Miller - Sister 4328 Ridge Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/2/2000 Baltimore, MD Parkwood Cemetery 21. Signature of Eugerer Server Lic 22. Nama and Addrass of Facility Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel COP. disease or condition rasulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 8 attending 98 0 ed by the a 23b. Did tobacco uea contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed t Š 24b. Were eutopsy findings available prior to should? 24a. Was an autopsy performed? Completed completion of causa of death? s certificate has b 1 Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Naturel 5 Panding 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 1-31-00 000 51924 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Ave 295 Stones

State Registrar

FEB 0 1 2000

Herbert

31. Date filed (Month, Dey, Year)

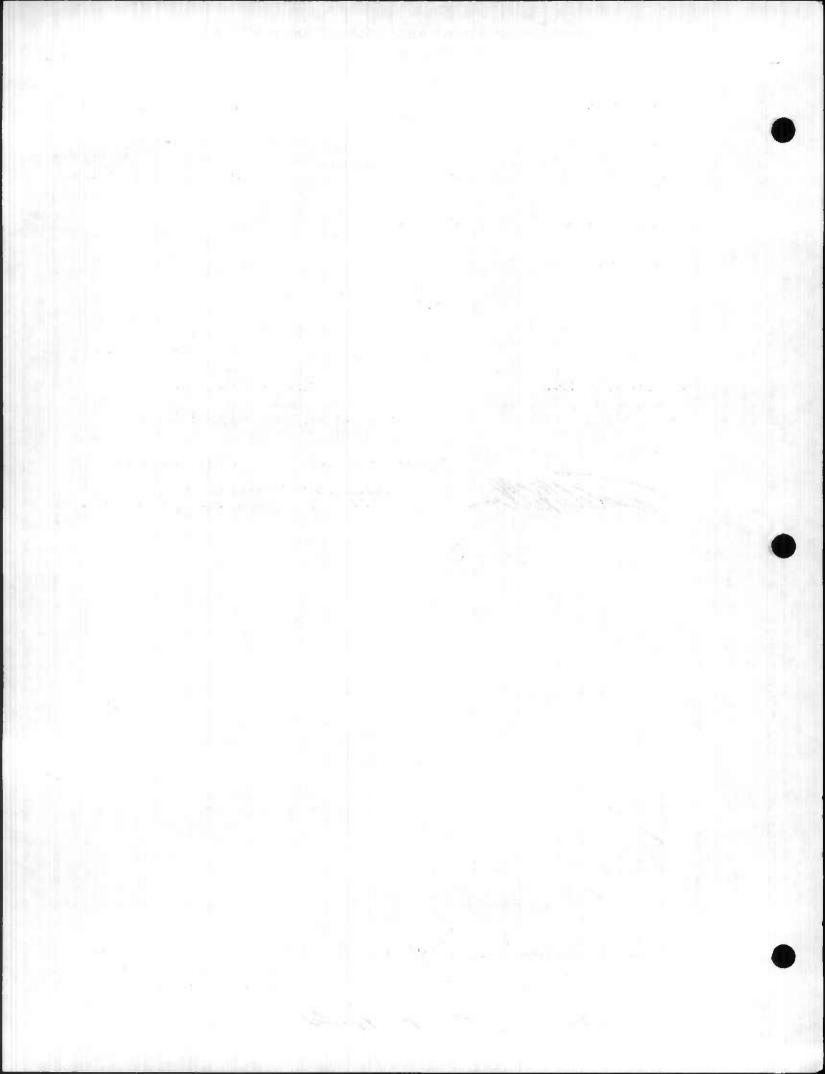
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Hen

32. Registrer's Signature

Mn

Westminster MI

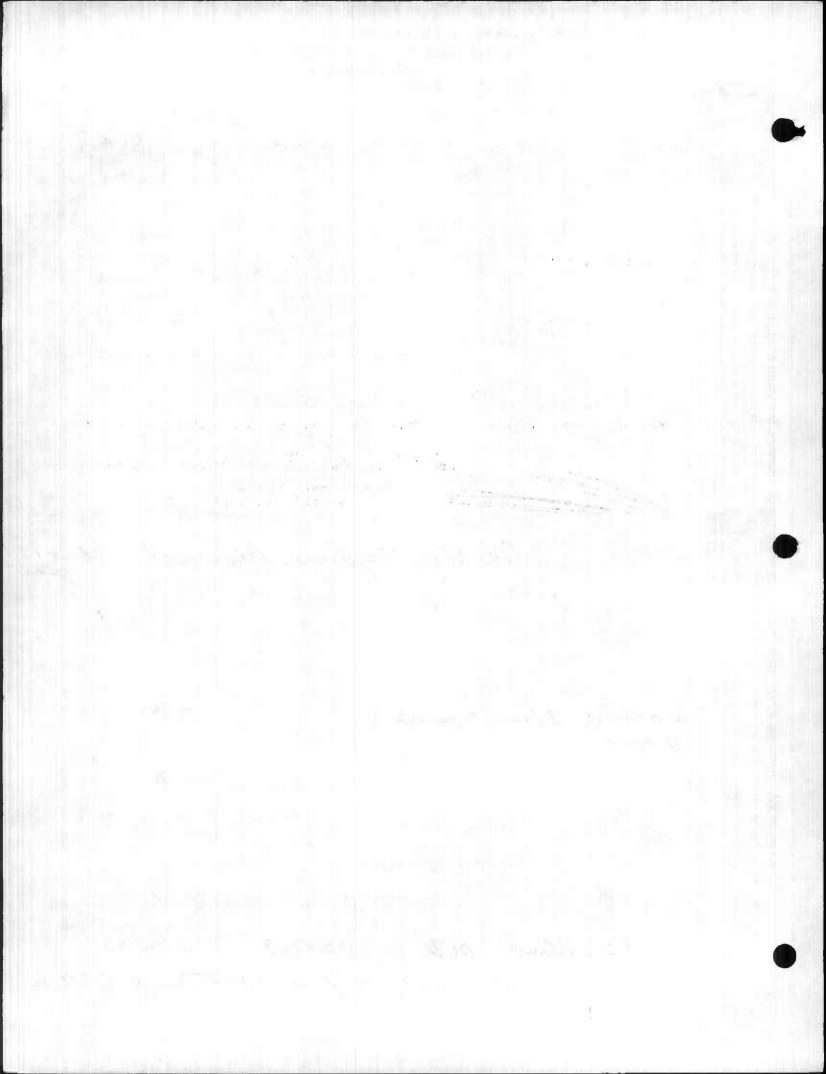


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Amended #2 per MD, 1/27/2000, SHS, Talbot Certificate of Death 1. Decadent's Neme (First, Middle, Last) 2. Dete of Deeth 1 23 XXXX 3. Time of Death Month **Physician** Beooks my /Medical a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHESTERTOWN NURSING

5. Social Security Number 6. Sex 7. Age (IA yrs. KERT + KEHMB nostertown 7. Age (In yrs. lest birthday) If Under 1 Yee If Under 24 Hrs 8. Dele of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 100 M 20 F Hours 69 Oct.6,1930 Director 214-30-8399 Maryland Usuel Residence of Decedani the Marylend 10e. Stete 10c, City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylen nent of Health and Mentel Hyglene.
Int: If Hem 27 is marked other than "natural", or Hams 23s or 28s-f show into or other traumatic event, and Mentel Exercited Transfer the non-vert state. 1 XYes 2 No Director Maryland Kent Chestertown 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21620 USA Funeral 316 Rosevelt Dr. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Meritel Status 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Deles: Bleck, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: Specify þ 3 ₩Widowed 4 Divorced **Black** Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Truck Driver State of Maryland 18. Mother's Neme (First, Middle, Maidan Surneme) 17. Father's Neme (First, Middle, Last) Alonza Lillian Brooks 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Gertrude Jones, Sister 25641 West Hill Rd., Worton, Maryland 21678 20b. Piece of Disposition (Name of cemetery, crematory or other piece)
Coleman's 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) New ChristainChaples Love 1/29/2000 Worton, Maryland
22. Neme end Address of Feclify 21. Signeture of Funeral Service Legal 10 Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Pertf. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** Immedieta Ceusa (Finel diseese or condition rasulting in daeth) /Medical multiple Mydowne, Advanced Examiner Examiner physician and the burial-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Ceuse (Diseasa or Injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificata has blirector, pege 2 s 2 No 1 Yas 2 No Attending Physician: 25. Was casa referred to medicel exeminer? 28. Place of Deeth (Check only ona) Be Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury al Work? Certification: After 1 Natural 5 Pending Investigation daath. 2 Accident 1 TYes 2 No i or Attendi efter daath Director: A d in by the fi 6 Could not be dataminad 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funerel Directorn pletely filled in the Cartifying Physician: To the best of my knowledge, deeth occurred et the tima, date end piece, and dua to tha causa(s) and mannar as stated.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred et tha tima, date end place, and due to the causa(s) end menner steted. 29e. Certifiar Medical (Check only one) 29c. License number 29d. Dale signed (Month, Dey, Year) 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Clesterboun, MD 2620 WUN 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State JAN 2 7 2000 D Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day COWGER LAWRENCE **EDWARD** J4NUANY 28, 2000 0244 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 6. Sex 1 № M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Yrs. 75 221-14-6745 10/01/1924 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pocomoke City Worcester 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21851 561 Ocean Highway Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 No Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Manager / Owner Construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Griffith See Clarence Cowger 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Larry Dean Cowger (son) 800 Walnut St., Pocomoke City, MD 21851 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/30/00 Pocomoke City, MD First Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furerel Service Licensee 22, Name and Address of Facility HOLLOWAY Melson Funeral Home, P.A. m01129 Dean 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) Due to (or as a consequence of): WIESTINES Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

physician and the burial-transit

Physician

/Medical

Examiner

Funeral

Director

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altimore,

Box 68760,

Division of Vitai Records, P.O.

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Department of Health and Ments Important: If Item 27 is marked

Director

Funeral

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Examiner Physician/Medical by Completed Be Certification:

To the Hospital or Attending r-within 24 hours after death. To the Funeral Director: After t 6+1

Registrar

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1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? 5 Pending Investigation 1 Neturel Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

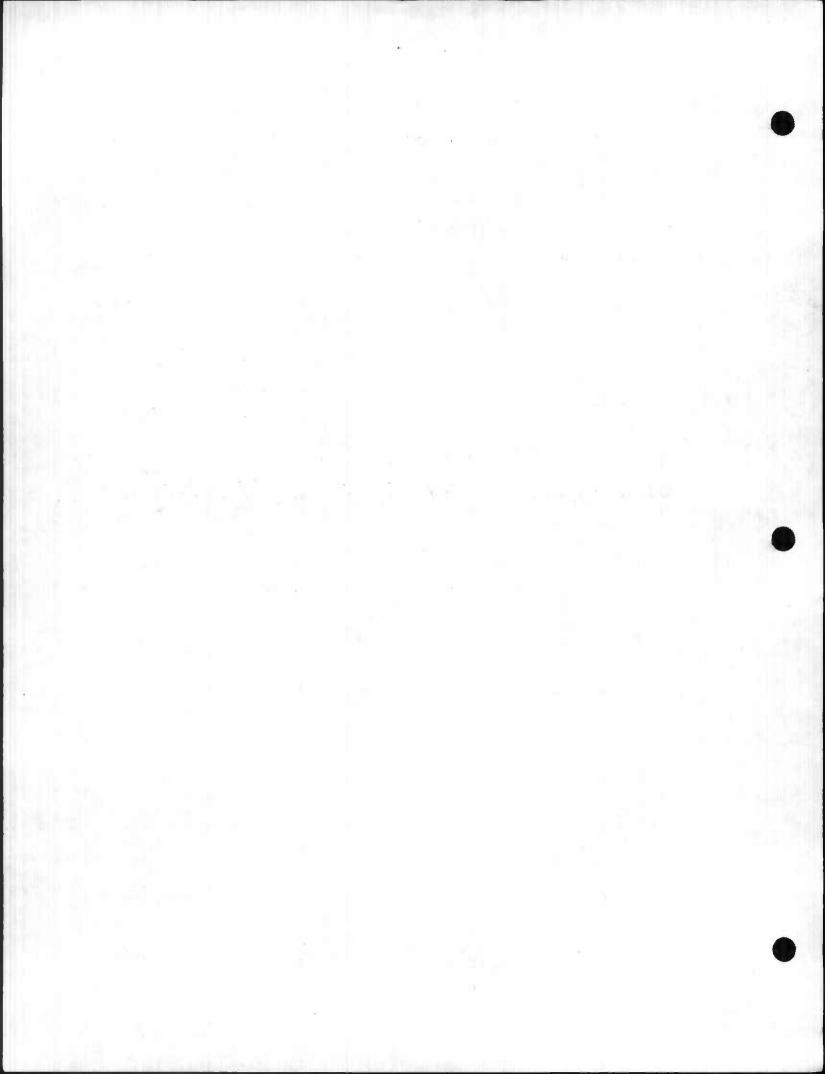
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

(Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

bur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

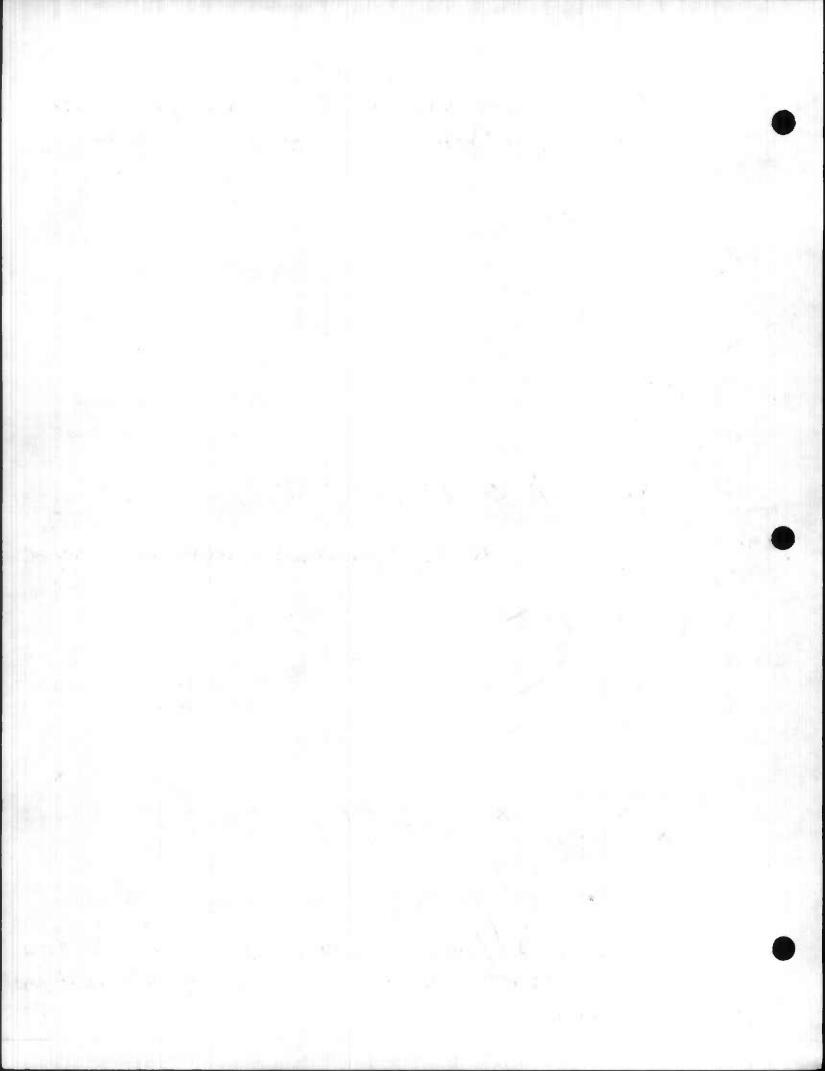
201 PINEBLUFF Rd. Suite 25, SAlisbury MD

Nicholas L. Ogburn 1. Date filed (Month, Dey, Year) 32. Registrar's Signature FEB 01



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| | Certificate of Death | | Reg. No. | 04477 |
|-----------------------|--|------------------------------|--------------------|--|
| | 1. Decedent's Neme (First, Middle, Last) | 2. Date of De Month | | 3. Time of Death |
| sician edical | Alan Wilbur Chance, SR. | Lanux | 27 | 2000 1925 |
| miner | 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Li | ocation of Death | 4c. County o | f Death |
| | University of Maryland Balti | more | 13 | altimore |
| | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Dete of Bir (Month, Da | th v. Year) | Birthplace (State or Fore Country) |
| | 213-78-8827 | MAY 21 | , 1960 | MARYLAND |
| • | Usual Residence of Decedent | | | |
| - | 10e. Stete 10b. County 10c. City, Town or Location | | | 10d. Inside City Lim |
| oto | MD TALBOT EASTON | | | 17 Yes 2□ |
| Director | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of WI | hat Country? |
| | 8632 CHESTER COURT 21601 | | USA | |
| Funeral | 11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No | - 14. Race | - American Indien, |
| _ | 1 Never Merried 2 Married 1 Yes 2 No | rican, etc., | | , White, etc. |
| 6 | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Detes: | | Specify: | WHITE |
| ١ | 15. Decedent's Education 16a. Decedent's Usuel Occupation | vina | 16b. Kind of Bus | iness/Industry |
| Ĺ | (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Elementery/Secondary (0-12) College (1-4or 5+) | ary | | |
| combinered | 12 -0- JOURNEY LINEMAN | | UTILIT | IES |
| 90 | 17. Father's Neme (First, Middle, Last) 18. Mother's Neme | e (First, Middle | Meiden Sumame |) |
| Ö | RONALD SMITHSON CHANCE HAZEL | EMILY C | ROUSE | |
| - | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rur | | | State, Zip Code) |
| | DAWN R. CHANCE/ WIFE 8632 CHESTER COURT, EA | STON, M | D 21601 | |
| | 20a Method of Disposition 20b. Place of Disposition (Name of | Date | | City or Town, Stete |
| | MCBurial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) SPRING HILL CEMETERY | -26-00 | EASTON, | MD |
| | 3 □Donetion 5 □Other (Specify) SPRING HILL CEMETERY U 21. Signature defuneral Segreta Licenses 22. Name end Address of Facility | -20-00 | LADION, | FID |
| clan/Medical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or es a consequence of): d. | | | |
| Physician/P | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | 23h Did | tobacco use con | tribute to the cause of de |
| hys | To the early estimated deviations controlling to country in the unconjung cause given an out. | | , | 3 Probably 4 ☐ Unk |
| by P | | | 74 | |
| 8 | | | an autopsy | 24b. Were autopsy findir available prior to |
| Completed | | perio | ormed? | completion of cause of death? |
| E | | | V. 26. | |
| | OF West and related to medical | 10 | | 1 ☐ Yes 25 No |
| Be | 25. Was case referred to medical examiner? Hospitel: Hospitel: Other: | | | 21-73 |
| . To | 12 inpatient 2 Ervoutpatient 3 DOA 4 Nursing Ro | | dence 6 Othe | |
| Certification: | 1 Netural 5 Pending (Month, Day Year) Injury Work? | 200. Describe | mijory occurre | |
| cat | 3 Suicide 6 Could not be | 28f Location (| Circuit and Number | r or Rural Route Number. |
| TT. | 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) | City or To | | , or noral noute Number, |
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| edicai | 29a. Certifier (Check only (Check only (Check only) (Check only (Check only) | | | |
| 9 | one) end menner steted. | | | |
| Σ | 29b. Signature and title of certifier 29c. License number | | 29d. Date signed | (Month, Dey, Year) |
| | 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) GLENN BARQUET 22 South Greene 3 31. Dete liled (Month, Dey, Year) 32. Registrene Signeture JAN 24 2000 Apacks | 4 | Januar | y 23 200 |
| | 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) | | | 1 |
| | GLENN BARRIET 22 South Greene S | Street | + Bat | Hore May |
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| trar | HAN 2 4 2000 > Begins B. Sports | | | |
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| Causa (Diseasa or injury het initiated evants asulting in daath) Last | Dua to (or | as a consequance of): | | | |
| Part If. Other significant conditions co | ntributing to death but not rasu | iting In the underlying ce | usa given in Part I. | 23b. Dfd tobecco use co | ontribute to the cause of death? |
| | | | | 24a. Was an autopsy parlormed? | 24b. Ware autopsy findings available prior to completion of cause of death |
| 25. Was casa rafarrad to medical axaminar? | Hospital: | ER/Outpatient 3□ DO | Other: | ath (Check only ona) Homa 5 ARasidance 6 □Oth | Canaibil |
| 17. Mennar of Deeth 1 D Neturel 5 Pending 2 Accidant invastigetion | | | 3c. fnjury at Work? 1 Yas 2 No | 28d. Dascribe how injury occur | |
| 3 Suicida 6 Could not be 4 Homicide determined | 28e. Placa of Injury - At hos building, etc. (Specify, | ma, farm, streat, factory | office | 28f. Location (Straat end Num) City or Town, State) | ber or Rural Routa Number, |
| 29a. Cartifiar 1 Certifying Phy (Check only one) | sician: To the best of my know iner: On the basis of examineti and mannar statad. | viedge, death occurred a on end/or invastigation, | it tha tima, date end plec In my opinion, death occ | e, and due to the causa(s) and murred et the time, dete end place, | anner as stated. and due to the ceuse(s) |
| 19b. Signature and title of confiner | tanen, | M.D. 290 | C.C.M.E. | | od (Month, Day, Year) ry 29, 2000 |

111 Penn Street, Baltimore, Maryland 21201

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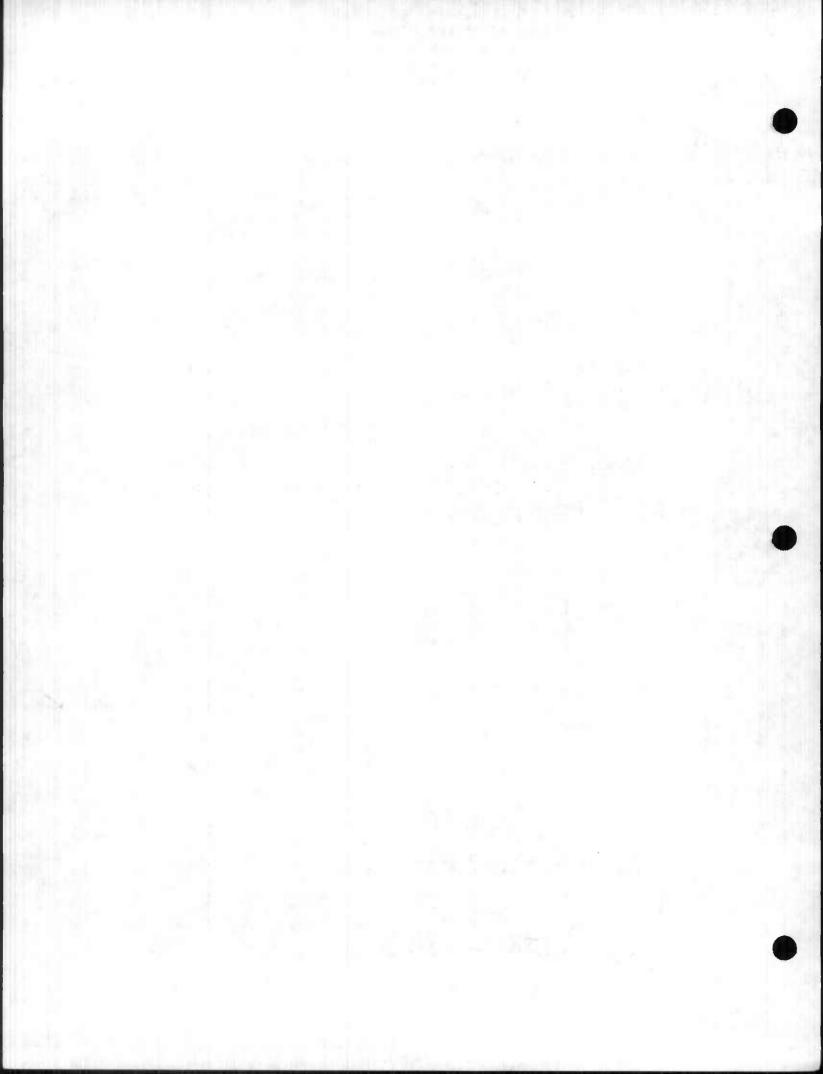
who completed cause of death (fem 23a) (Type, Print)

32. Registrar's Signatura

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Please Type or Print In Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 24, 2000 9:40 PM JAN. CHARLOTTE COLE 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2♥ F Ves 404-66-5475 AUG. KENTUCKY Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No MONTGOMERY GATTHERSBURG 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 20878 817 QUINCE ORCHARD BLVD. #32 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER AT HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES SHORT PRFIE ISABELLE FUGATE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLOW CASSANDRA STARR COLE/DAUGHTER APT. 5C HAPPY HOLLOW, MIDDLESBORO, KY. 40965 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1/29/00 RIVERDALE, MD. 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 MOOO91 CHAMBERS FUNERAL HOMES, P. A., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Fine) 1 week disease or condition resulting in death) week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of): cha week Due to (or es a conseg week 23b. Did tobacco use contribute to the cause of death? Part II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown -01 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? eabeter 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medicat exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 PInpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Exempler must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked other any Injury or other traumatic event BOBS.

after

Baltimore, Maryland 21215-0020

Director

Funeral

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The law requires that the death certificate be axecuted

Box 68760.

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Division of Vital

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Certification: To this funeral To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

Physician/Medical þ Completed Be

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State Registrar

29b. Signature englittle of certifier mallon

5 Pending investigation

6 Could not be

MD

28a. Date of Injury (Month, Day Year)

29c. License number 05/7/4

28c. Injury at Work?

1 | Yes 2 | No

Blud #102.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year)

MD 20850

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

Rockvello.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Jetender S. Selkhon . 2401

Kesearch

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year) JAN 31 2000

27. Manner of Death

1 Naturel

2 ☐ Accident

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

32 Registrar's Signature

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| pe or Print in Black Indelible In State of Maryland / Department of Certificate of | | 04425 |
|--|--|----------------------------|
| | 2. Date of Death Month Day Year Jan. 26, 2000 | 3. Tima of Death 3:44 P.M. |
| eet and numbar) | 4b. City, Town, or Location of Death 4c. County of Dea | th |

Physician /Medical Examiner

Funeral Director

the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at with death

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural; or itel any injury or other thaumatic event, the Medical Example

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

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certificate

After

Box 68760

P.O.

Division of Vital Records.

Physician:

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death certificate

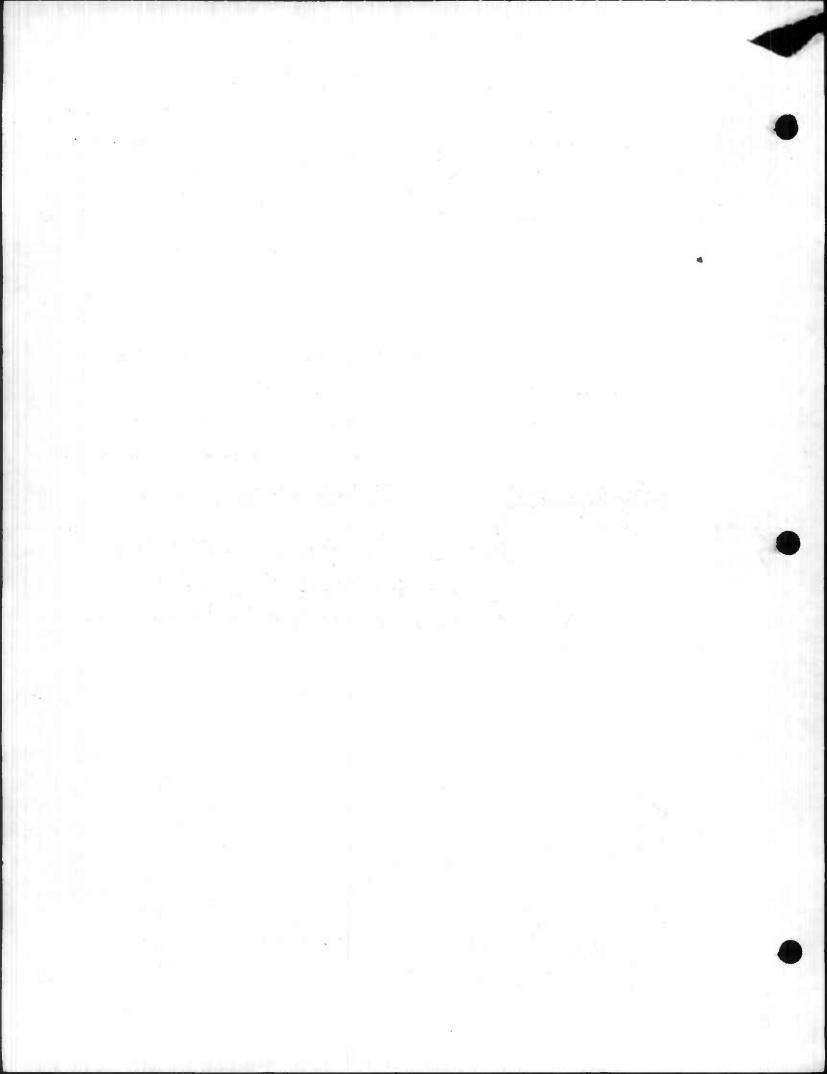
burial-transit physician a Se esn signed by the atte page 2 funeral director,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the illed in by npletely 1 20

1. Decedent's Name (First, Middle, Last) Crawford Lee Cole 4a. Facility Name (If not institution, give stre Ft. Washington 7011 Haverhill Street Prince Georges If Under 1 If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1□XM 2□ F Vrs 74 3-12-1925 North Carolina 245-28-9587 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 X No Prince Georges Ft. Washington Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7011 Haverhill St. 20744 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Marltal Status 1 Never Married 2 Married tX Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Yes 2 ☐xNo Specify: White 3 Widowed 4 Divorced by Completed 15. Decedant's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) WTOP (Channel 9) Technical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Crawford Calvin Cole Pearlie Meechum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrica Cole (daughter) 5020 Willowmeasde, Fairfax, VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairfax Crematory 20a. Method of Disposition
1 □ Burlal 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date 1-30-00 Fairfax, VA 22030 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly Funeral Home 10565 Main St Fairfax, VA 22030 Jary aleve 23a: Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immadiate Cause (Final disaasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ck only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifie License number 30. Nap Day, Year) 31. Date filed (Month, 32. Registrar's Signature 3

State Registrar



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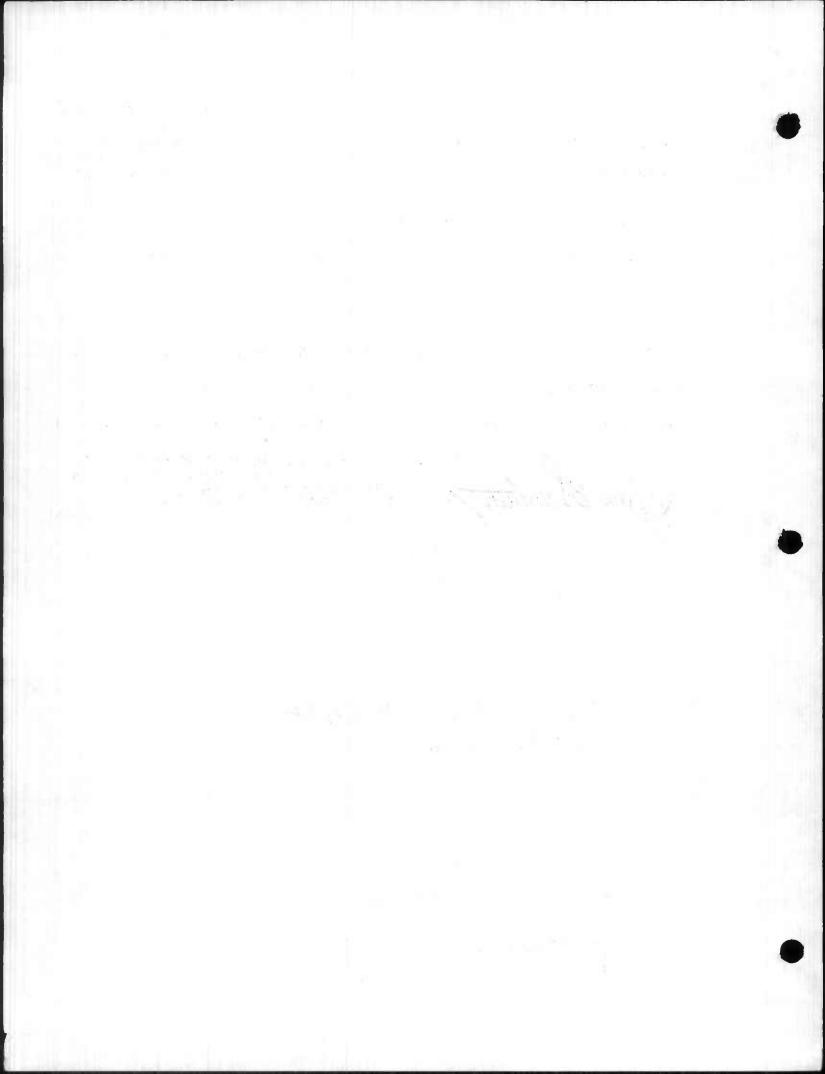
State of Maryland / Department of Health and Mental Hygiene

04426 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 23, January 2000 4:26 PM Helen Κ. Condon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 1□M 2☑F 79 578-16-5685 Yrs Director Oct. 14, 1920 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be nutfled at 1 ☐ Yes 2 No Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? ò Itams 23a 600 Clayborn Avenue 20912 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. the Medical Examiner Pages 1 end 2 should be filed within 72 hours effer nent of Heelth and Mental Hygiene. int: If Item 27 is marked other than "natural", or Ita 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation

Air blind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary U.S. Dept. of Navy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Ernest J. Kientz, Sr. Albertina Lundgren 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth a important: if Item 27 is any injury or other tra Paul F. Condon, Jr. / Son 600 Clayborn Avenue, Takoma Park, Maryland 20912 20b. Ptace of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. 01/31/00 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home a.of Funeral Service 11800 New Hampshire Avenue Silver Spring, Maryland er the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical nte Ceuse (Finel 22310 disease or condition Examiner resulting in death) Due to (or es a consequence of): Examiner olihs physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lasf Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? the á 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown Records, by 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy peen 1 Yes 28 No 1 ☐ Yes 2 ☐ No certificete Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

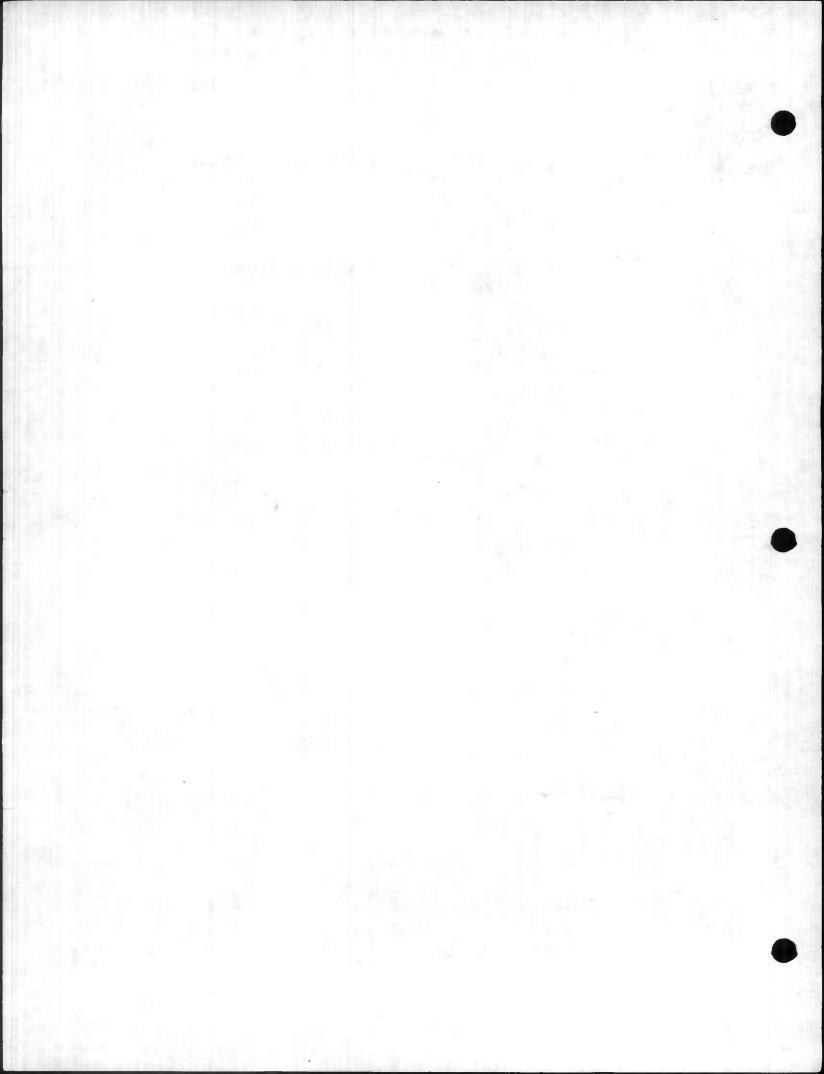
To the Funeral Director: Affer this certifica completely filled in by the funeral director; to Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title, of certifier 29c. License number D45660 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) LN, Solo 124, Bowie MD Month, Day, Y Pegistrar's Signature 31. Date filed (Month. State Registrar

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| Maryland 21215-0020 | 72 hours after natural, or its fical Examina | 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: | | 1 ☐ Yes 2] | | | Hican, etc.) | | ck, White, by: WH] | |
| il. | math filtra | 15. Decedent's (Specify only highest) | | 16a. | Decedent's Usual (Give kind of work | Occup done | pation during most of work ad) | ing | 16b. Kind of B | lusiness/In | dustry |
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| | | 30. Name and address of person wh | | oth (item 23a) (| | | Chancal P | -144- | | 1 2 | 21201 |
| - | Chata | Margarita Kore 31. Date filed (Month, Day, Year) | I.I. M.D. 32_Registrer | 's Signature 4 | | | Street, Ba | TTIMOR | e, Mary | ı.and | 21201 |
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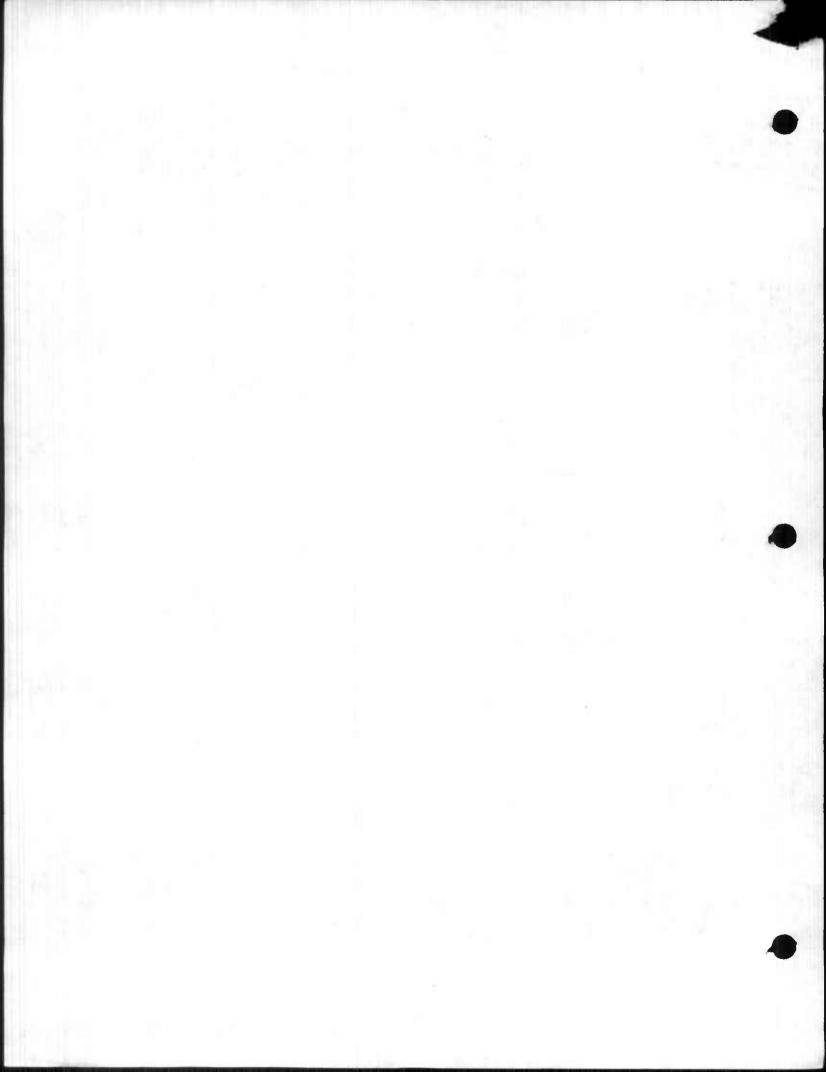


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death RICHARD CURTIS CARL January 18, 2000 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick Frederick If Under 1 Year ff Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□ F Yrs. 237-14-5360 Oct. 30, 1913 North Carolina Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick XX Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Delaware Road 21701 United States 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Vas 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) District Manager Southern States 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Robert S. Curtis Myrtle Spangler 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anita E. Register Curtis, wife 408 Delaware Road Frederick, Maryland 21701 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 1/21/00 Frederick, Maryland Olivet Cemetery 22. Nama and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Fungral Service Licega 1621 Opossumtown Pike Frederick, Maryland 21702 alvag anne Do not enter the mode of dying, such as cardiac or raspiratory arrest, tmmediate Causa (Final 2 mitts adenrevenena diseasa or condition rasulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown

Physician /Medical Examiner

The law requires that the death certificate be assecuted

certificate

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After

within 24 hours after death. To the Funeral Director: A

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Hospital

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Box 68760.

Records, P.O.

Division of Vital or Attending Physician: **Physician**

/Medical

10a. State

Examiner

Funeral

Director

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.. Peges 1 and 2 should be filed v tment of Health and Mental Hygie tant: If itam 27 is marked other to jury or other traumstic evant, to

Department of Important: If any Injury or

death

filed within 72 hours after

21215-0020

altimore, Maryland

Director

Funeral

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Be Completed

To

for use page 2 funeral director, filled in by

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Completed by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? 5 Panding forwastigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier (Check only one)

Registrar

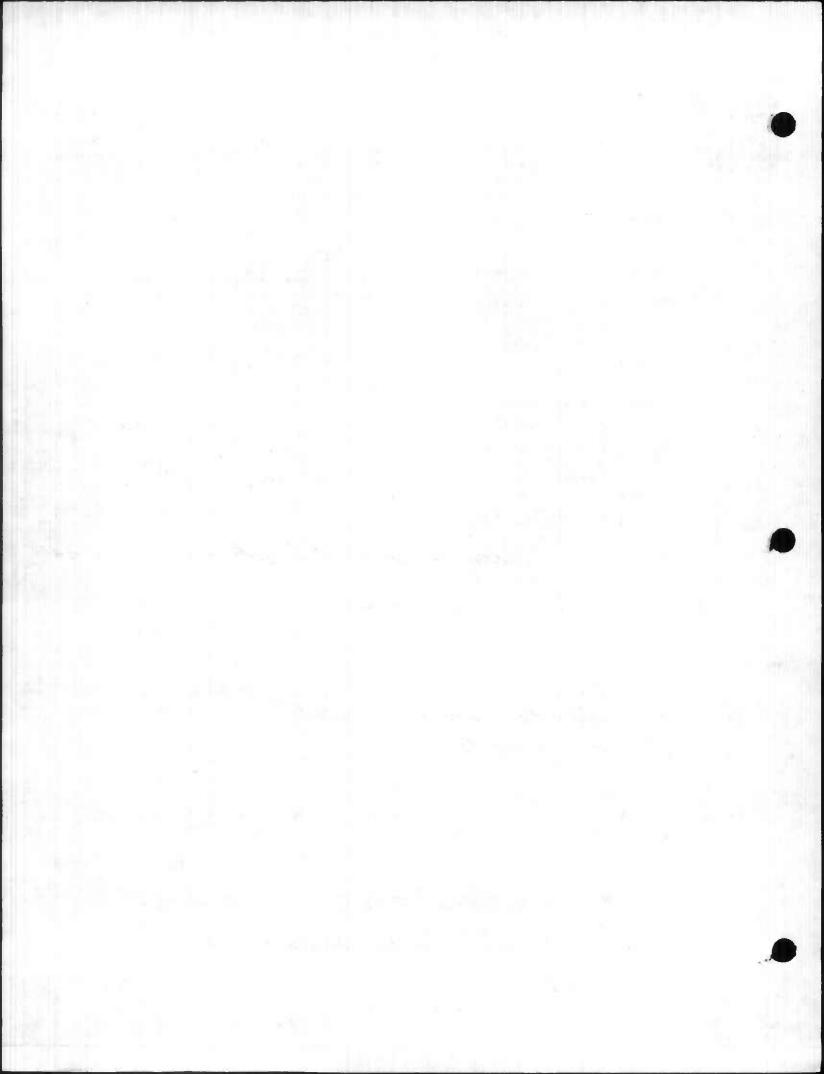
ecker 32. Registra Signatura State 2000

30. Nama and addrass of person who comptated causa of death (flem 23a) (Type, Print)

29b. Signatura and titla of certifier

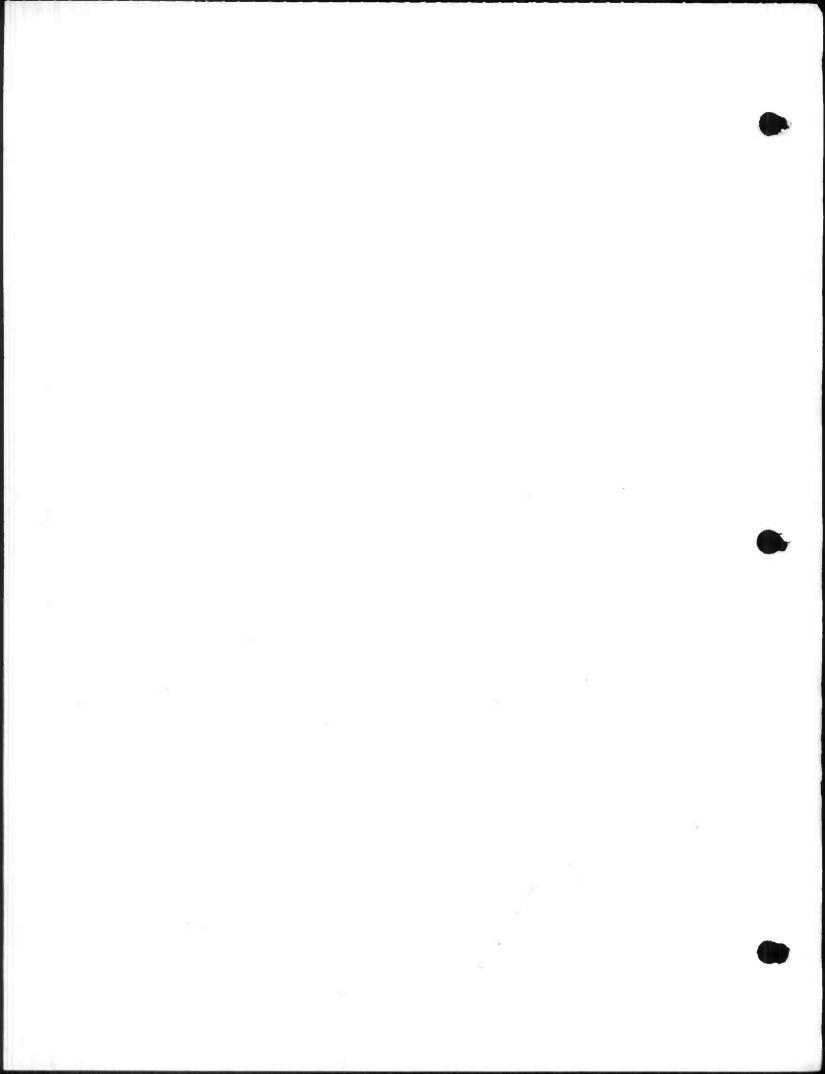
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29c. License number



| OT OF OTHER | TO BE COMPLETED BY DEVOICION, MEDICAL CERTIFICATION | |
|---|--|---|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| ie Tuneral oirector, page 5 should be detached al. | O THE FUNEXAL UNKLIVE. AIMS THIS THIS THE TABLE HAS DEEN SUPPORT BY THE ALEMANING PRYSICIAL AND COMPRESSY THE TABLE OFFICIOR, PAGE 5 Should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. | Y |
| r death. Page 6 may be retained by the hospi | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi | (|
| DALIIMORE, MARTLAND | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF MARY | | MENT OF H | | MENTAL HYGIEN | E | |
|--|--|--|---|--------------------------------|--|------------------------------------|--|
| - ANTONO | 1. DECEDENT'S NAME (First, Middle, Last) Margaret Elizabeth Crum | | | | January 2 | 5, 2000 | 3. TIME OF DEATH 7:30 PM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest b) $220-01-0394$ 1 \square M 2 \maltese F 97 | | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 8. BIRTI | IPLACE (State or Foreign |
| OR | 99. FACILITY NAME (if not institution, give street end number) Citizens Nursing Home | 91 | Freder | R LOCATION OF DE | ATH | 9c. COUNTY OF D Frederi | |
| DIRECTOR | 100. STATE 10b. COUNTY Maryland Frederick | 10c. CITY, T | own on Locat lerick | ON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| FUNERAL | 100. STREET AND NUMBER 3218 Basford Road | | 101. | 21703 | | 10g. CITIZEN OF V | WHAT COUNTRY? |
| B⊀ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMI FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES | ED | 13. WAS DECI If yes, spe 1 YES | cify Cuban, Mexices | IC ORIGIN? (Specify Years, Puerto Ricen, etc.) | or No- 14, RACI Black Spec | E — American Indian, k, White, etc. |
| COMPLETED | (Specify only highest grade completed) (Give | DENT'S USI kind of work to NOT use re memak | , | N It of working | 300 000 000 | Home | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Millard Ernst Barthlow | | | Elizab | ME (First, Middle, Maiden eth Franc | sumame) es Burk | e |
| TO B | Mr. Charles C. Crum, Jr. Son 3 | MAILING AO 202 E | Basford | Rd., Fr | oute Number City or Tow ederick, M | id 21703 | |
| | AN Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) | atory or other | DISPOSITION (Nai Disce) Cemetery | , Jan. 29, | 2000 Fre | ederick, | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSALE MO0255 | | Keene | y and Ba | sford PA F | uneral H | ome |
| ETED BY PHYSICIAN: MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEOU C. DUE TO (OR AS A CONSEOU D. | ENCE OF): PAL ENCE OF): PAL ENCE OF): PAL ENCE OF): PAL ENCE OF): DOA DOA DOA DOA DOA DOA DOA DO | Synthe underlying NO D Check only one) THER: Nursing Home WO M 1 2 Y | UNCERTAIN 5 □ Residence | Pert I. 24a. WAS AN PERFOR | AUTOPSY 24b MED? 24b NJURY OCCURED | Interval Batween Onset and Daath IDAYS DAYS WEEK YEAVS WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| E COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death one) 2 MEDICAL EXAMINER: On the best of examination end/or inv | | | | time, date end place, en | d due to the ceuse(e | |
| TO BE | 30. HAMP AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM: | | | D475 | 576 | ►1/25, | 2170Z |
| | 31. DATE FILEO (MAN 2 7 2000) 32. REGISTRAR'S SIGNATURE | 6. | Som | CHNICH | DRIVE, F | NENEL | ict, iMV) |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death ^{Day} 2000 Month 31, Charles Chervenie 1120 Jan. 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 11096 Brownstone Road Princess Anne Somerset 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 06/14/1916 Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) Sex. 1MM 2□ F Months Deys Hours 051-16-0666 Yrs. 83 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 11096 Brownstone Road 21853 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Engineer Aeronautical 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Chervenie Carrie Strinad 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul B. Chervenie/Son 37 Hill Street, Apt. A1, Morristown, N.J. 07960 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/2/2000 Salisbury, Md. 21) Signature of Funerel Service Licensee 22. Name and Address of Fecility Hinman Funeral Home Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Princess Anne, Md. 21853 Approximate Interval Between Onset and Death 6 moz. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Due to (or es e consequença of)

Physician /Medical Examiner

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Division of Vital Records, P.O.

permit. Pages 1 and 2 should be litted will Department of Health and Mental Hygien important: If them 27 is marked other than any Injury or other traumatic event, the ODGs.

Physician

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than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filled within 72 hours after Hygiene. Ther than "natural", or the

Baltimore, Maryland 21215-0020

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Funeral

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Examiner Physician/Medical by Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 2

Certification:

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ♠ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify)

27. Manner of Death 28a. Date of Injury (Month, Dey Year) 1 Neturel 2 Accident 5 ☐ Pending Investigation 6 ☐ Could not be 3 Suicide

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

28f. Location (Street and Number or Rurel Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Dey, Yeer)

ream

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Stegman, M.D., Mt. Vernon Road, Princess Anne, Md. 21853 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature

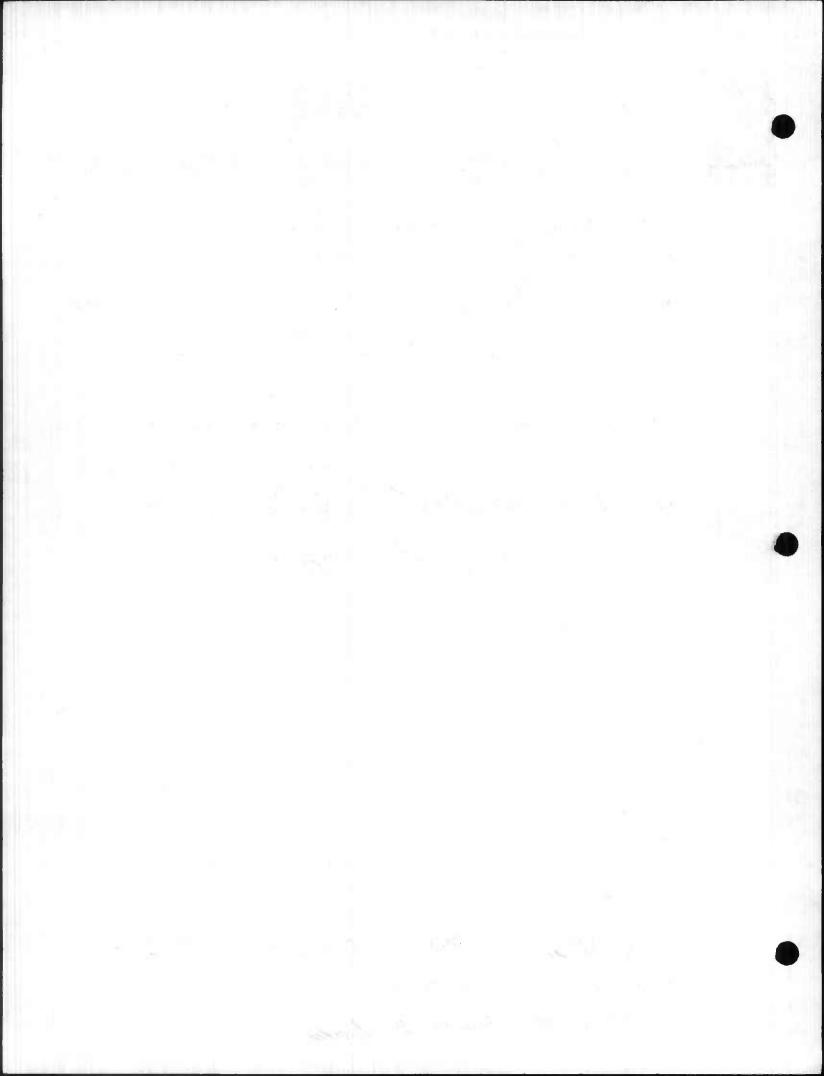
State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 24 2000 8:30PM E. Elizabeth Devilbiss 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Carroll Union Bridge 885 Trevanion Rd. If Under 24 Hrs. 8. Date of Birth Hours Min. A pt. 4929 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Months North Carolina 70 228-32-9101 Yrs. Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 10b. County 1 Yes 2X No Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21791 885 Trevanion Rd. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) public school 11 cafeteria worker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Vida Harrold Rosco M. Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) Robert S. Devilbiss/ son 885 Trevanion Rd. Union Bridge, MD 21791 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 2 Buriai 2 ☐ Cremetion 3 ☐ Removel from State Paul's Lutheran Cem. 1/27/00 Uniontown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHartzler Funeral Home 21. Signature of Furferel Servica License 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that car and the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each time. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequenca of) Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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within 24 hours after death To the Funeral Director: A completely filled in by the

death.

The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Certification: To

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Physician

/Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

r than "natural", or items 23s or 28s-f show to Medical Examiner must be notified at

the Maryland

death with

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, tra Menta page.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2 No

1 Yes 20 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signetule and title of certifier

25. Was case referred to medical examiner?

2 NO

1 Yes

27. Manner of Deeth

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and manner stated.

5 Pending

Investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

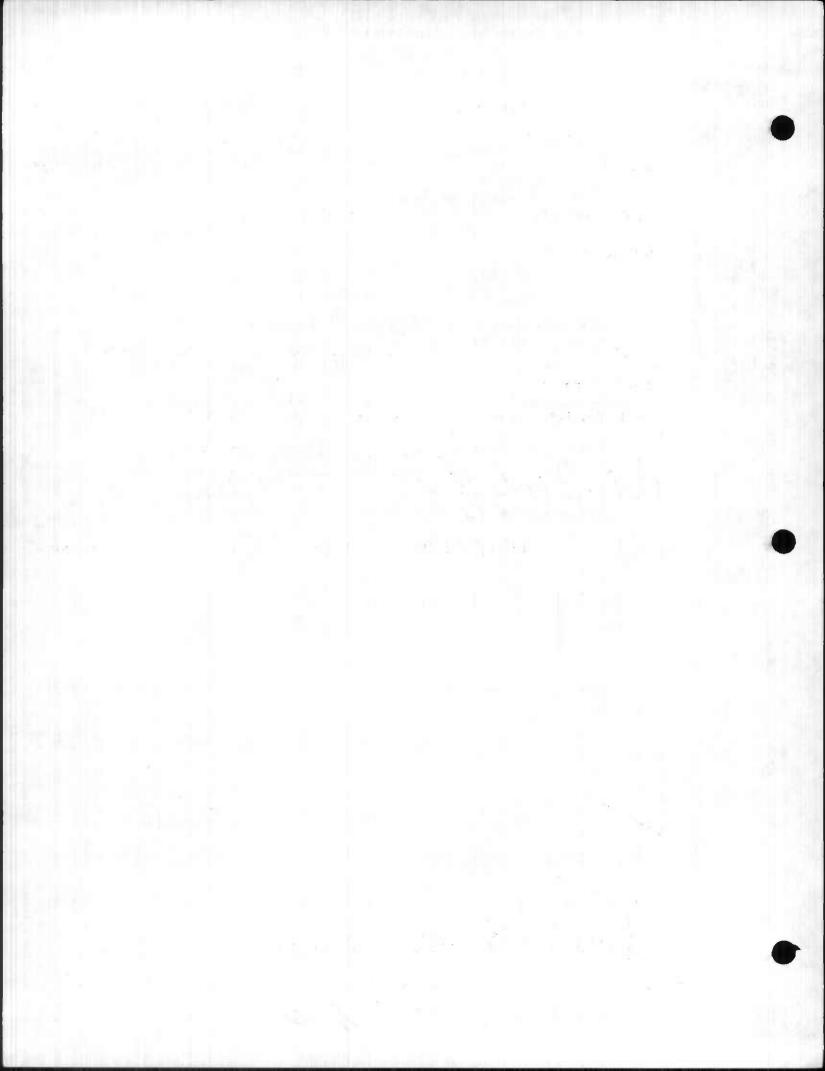
Westmaster, MD 21157 224 Washington Ideaphys Flavio Kruder 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

1 Inpatient 2 ER/Outpatlent 3 DOA

28b. Time of

Registrar

28a. Date of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey JANUARY 26, 2000 cation of Deeth 4c. County of Deeth 1357 ROBERT E. DEAN 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) PARK CLINTON PRINCE GEORGES OSCA 11603 If Under 24 Hrs. 6. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 11 M 2□ F Months Days Yrs. 58 Penn. 577-56-8433 Jan. 23, 1942 Usuel Residence of Decedent 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1⊠Yes 2□No Clinton MD Prince Geo. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11603 Cosca Park Drive U.S.A. 20735 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American tndien, Bieck, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 Vrs Elementery/Secondery (0-12) Printer U.S. Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Robert L. Dean Jewel Cobb 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Kathleen V. Dean (Wife) 11603 Cosca Park Dr., Elinton, MD 20735 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Deuriel 2 Cremetion 3 Removel from State Lincoln Mem. Cemetery2/4/00 Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licenses 22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. no Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting In deeth) . HYPERTENSIVE CARPIOVASCULAR DISEASE MISORNER SEIZURE Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert It, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings avelleble prior to 24e. Wes en eutopsy completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Neturel 2 Accident 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcide

physician and s the burial-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attanding Physician: After this death. after death Director:

attending ph for use as t signed by the a been si certificate has b lirector, page 2 s funeral in 24 hour.
The Funeral Directory filled in by the

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

than "natural", or itema 23a or

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Introcritant: If Item 27 is marked other than "natural", or items 28a and injury or other traumatic event, it a Medical Exercises 28a enter.

Physician /Medical

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Certification:

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29a. Certifier

29b. Signeture,

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MARIO 31. Dete filed (Month, Dey, Year)

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Baltimore, Maryland 21215-0020

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> State Registrar

1 Certifying Physictan: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s)

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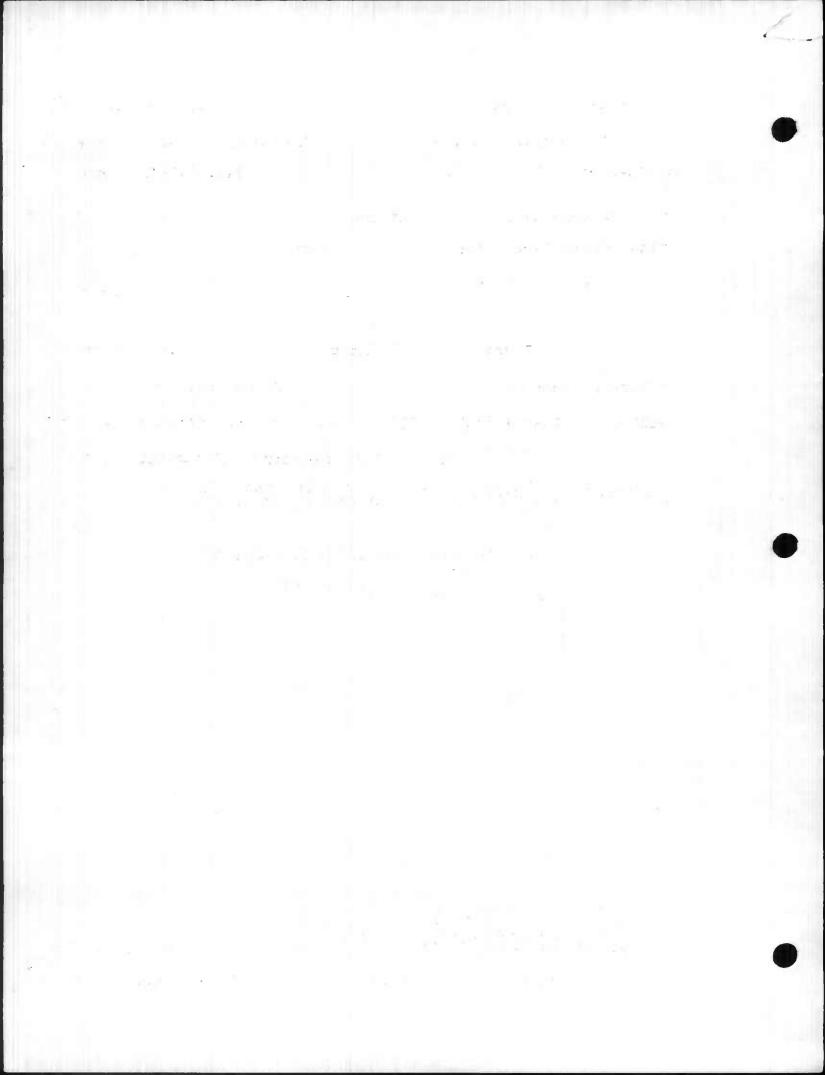
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30. Name end eddress of person who completed (ause of deeth (Item 23a) (Type, Print) 3001

29c. I Icense number

29d. Dete signed (Month. Dev. Year)

32. Registrer's Signeture

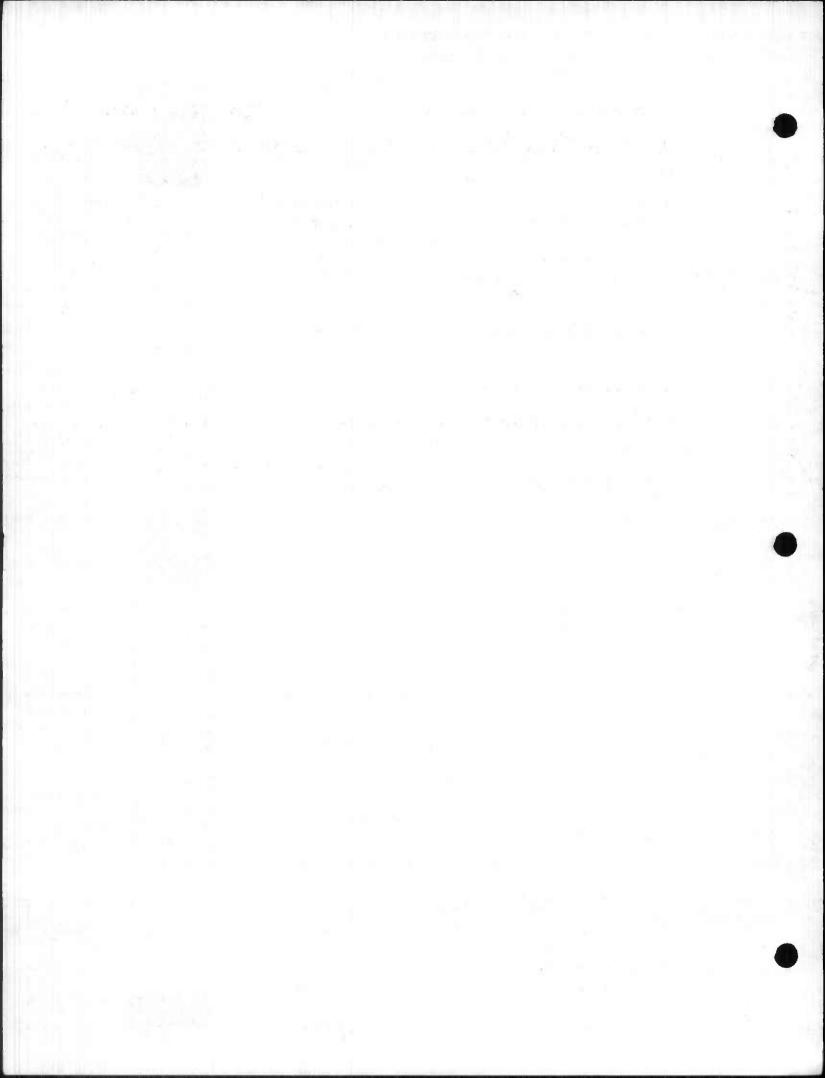


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** James Cullen Dalrymple, Sr. 1236 30 2000 Manuall /Medical 4a. Facility Neme (If not Institution, give street and number) City, Town, or Location of Deeth 4d County of Death **Examiner** If Under Yeer rida enera STRE 12 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpiece (Stefe or Foreign Country) **Funeral** 18 M 2□ F Months Deys Hours Min Yrs. 20, 1939 214-36-3832 60 Director June Michigan Usual Residence of Decedent 25a-f show notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Director Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? iner mat be r 751 Hills Point Rd. 21613 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 1 XYes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) the Medical Examiner 1 Never Merried 2 Merried Maryland 21215-0020 b 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced 'natural'. White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) Mechanic Automotive Pages 1 and 2 should be filed veneral of Health and Mental Hygie ant: If Item 27 is marked other f 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Lewis Dalrymple Helen Fellows Beeman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Dalrymple/Spouse 751 Hills Point Rd., Cambridge, MD 21613 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete b 1 ☐ Burial 2 【XCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cambridge Crematory2-2-2000 Cambridge, MD 21. Signifure of Funeral Service Licenses 22. Neme end Address of Fecility
Curran-Bromwell Funeral Home, P.A. 208 High St., Cambridge Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and heart failure. List only one cause on each line. 308 High St., Cambridge, MD Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine rea disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Examiner DONIA eutro physiclan and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): Division of Vital Records. P.O. Box 68760 The law requires that the death certificate be Physician/Medical CARCITONA for use as cell signed by the ail Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should b 24b. Were sutopsy findings aveileble prior to Completed 24e. Wes an autopsy performed? completion of cause of death? certificate has 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 8 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 Neturel il or Attending s after death. il Director: Aft 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide To the Hospital o within 24 hours aff To the Funeral Di completely filled Ir 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who co pleted cause of deeth (tem 23e) (Type, Print) AUCOCA 12

DHMH 16 Bev 6/95

State Registrar 31. Dete Hill (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 04435 Amend #29d, 2/2/2000, BMW, Montq. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert Eldon 29, 2000 January 9:40 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health - Kensington Kensington
HUnder 24 Hrs. 8.
Hours Min. Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 XM 2 ☐ F 579-34-4335 77 June 8, 1922 Director Michigan Usual Residence of Decedent 10a, Stata 10b. County 10c. City. Town or Location 10d, Inside City Limits e filed within 72 hours after death with the Manylen Li Myslene other than "natural", or flarms 23a or 28a-1 show vent, the Madies! Exeminar must be notified at 1□ Yes 2No Director Prince George's Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9000 Briarcroft Lane #314 20708 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indien, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 12 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: n Yes, Give Year or Dates: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Legal Attorney permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked other any Injury or other treumstic event Potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Ernest D. Dick Gertrude Dahl 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2624 Kirkwood Place #104, Hyattsville, MD 20782 Debra R. Dick / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home, Inc. Stem! 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Sepsis Examiner Due to (or as a consequence of): Examiner Renal Insufficency that the death certificate be executed physicien and s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Atrial Fibrillation Physician/Medical Due to (or as a consequence of): ettending i Pneumonia P.O. signed by the d 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hiatal Hernia of Vital Records, à The lew requires 24b. Were autopsy findings Completed 24a. Was an autopsy performed? aveilable prior to completion of cause of death? Cardiac Pacemaker s certificate has b director, page 2 s 1 Yes 2 No 1 Yes 2 No al or Attending Physician: The star death.

I Director: After this certificated in by the funeral director, pages of the physician death. 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 27. Mapper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Division 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-31-2000 Š. 6007 300 au 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Kathleen McShane, MD

0 2 2000

FEB

31. Date filed (Month, Day, Year)

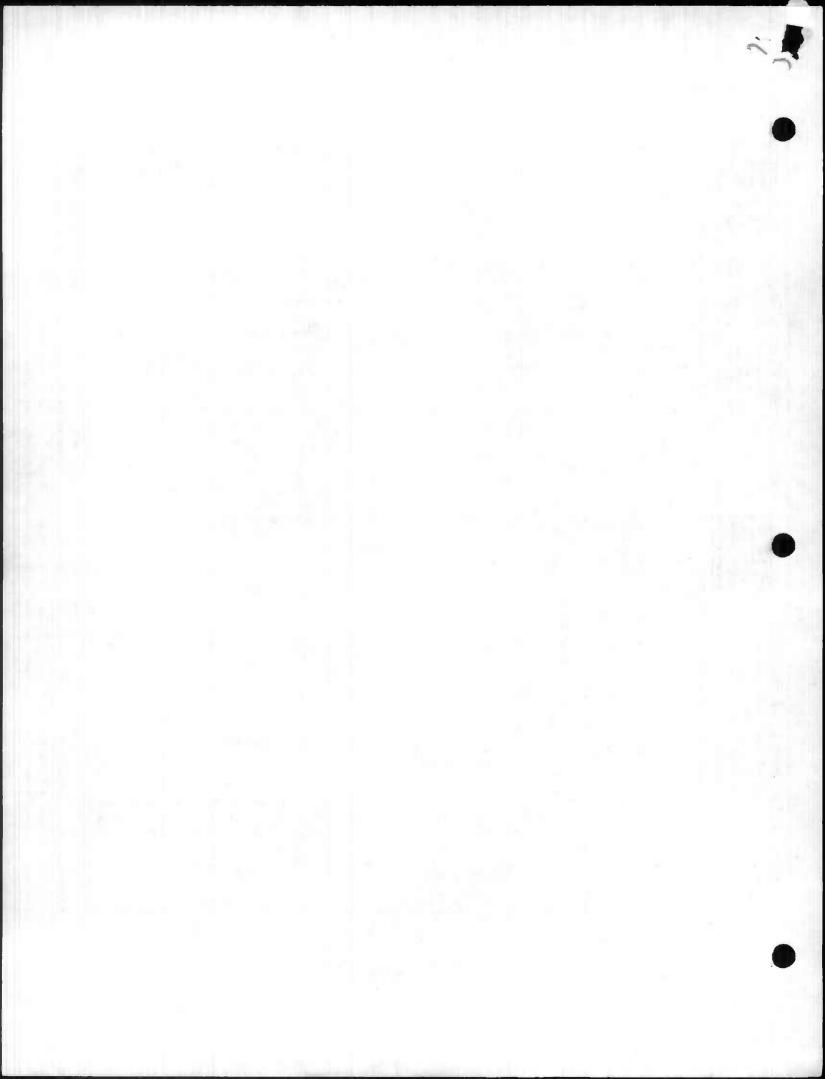
32. Registrar's Signature

Seneva

Kaiser Permanente, Silver Spring, MD

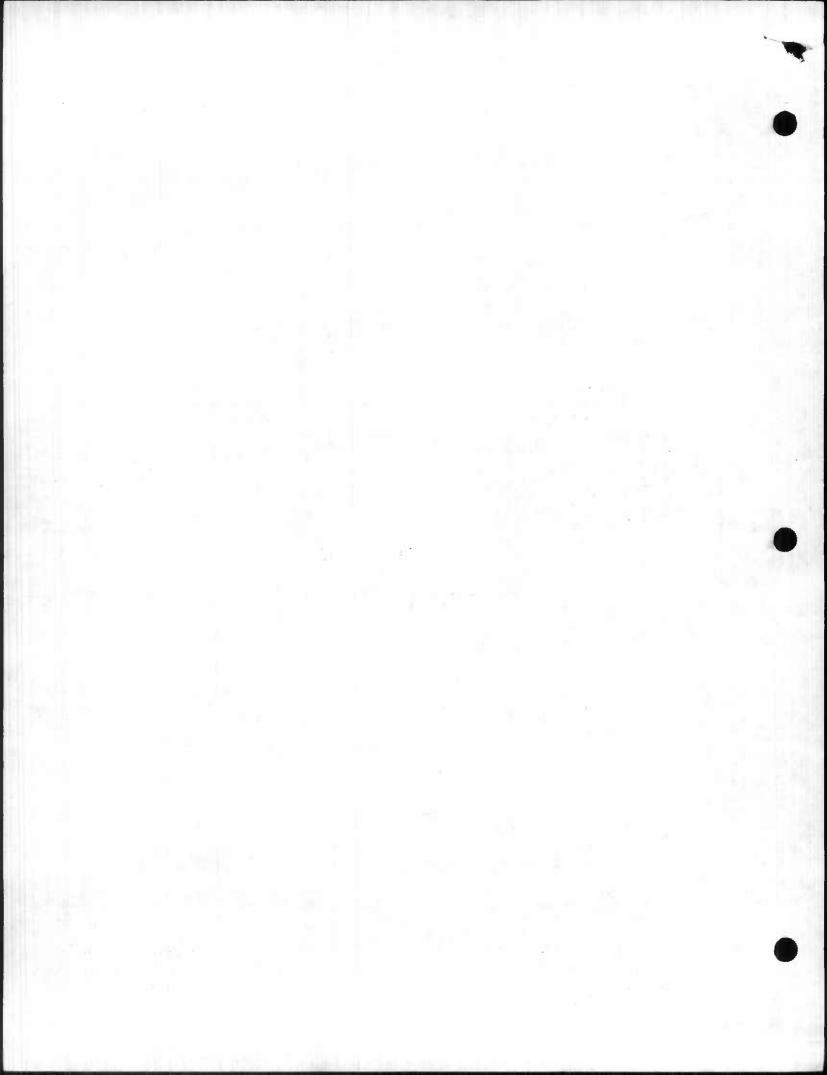
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 16436 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26.1/31/2000.BMW.Monta.Co. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 17,2000 **Physician** orman JANUARY 7:03 P.M. IVVEr /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIRCH WAY ELKRIDGE HOWARD 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F 577-44-3523 67 DEC. 3,1932 WASHINGTON, D.Q Director **Usual Residence of Decedent** 10s State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No Director HOWARD ELKRIDGE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? na 23a or 7 UNITED STATES OF AMERICA 6717 PIRCH WAY 21075 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Marital Status e filed within 72 hours after de of Hygiens. other than "naturel", or flams vent, to Medical Example or Black, White, etc. 1 Never Married 20 Married Baltimore, Marviand 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SALES CLERK HARDWARE STORE i. Pages 1 and 2 should be filed wi trnent of Health end Mentel Hygien tanti: If them 27 is marked other th jury or other fraumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNOBTAINABLE FRANCES DIVVER 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY G. DIVVER/SPOUSE P.O. BOX 1609 PRINCE FREDERICK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If I eny injury or once. 1/24/00 LINCOLN CEMETERY BRENTWOOD, MARYLAND 22. Name and Address of Facility 21. Signature of Suneral Ser ie Lib RAYMOND-WOOD FUNERAL HOME, P.A. VYR P.O.BOX 430 DUNKIRK, MARYLAND or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest list only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical diate Cause (Fig 0 Examiner Due to (or as a consequ Certification: To Be Completed by Physician/Medical Examiner attending physicien and for use as the burlel-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.0. Part II_Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? VISCASE monar completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; I 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 Inpatient 2 ETVOutputient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. (Check only ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 735217 Jan 20,2000 10 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 11055 Little Paturent Pkury. #210 Culumbia, MD 21044 JACKLION DAVID MI 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 3 1 2000 Snew oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4437 Certificate of Death 2. Data of Deeth 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month Voor **Physician** 1145 MICHAEL ROBERT DONOUTIN LAMINAT 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3398 GLEN EHGLE DRICK SILLER SAUL-MONTGOMMY 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

-- Yrs. | Months | Deys | Hours | Min. | Min. | March | 29, 1942 | Washington, D.C. 5. Social Security Number 9. Birthplaca (Stata or Foreign **Funeral** 1**∑**M 2□F 217-42-1308 Director Usual Rasidanca of Dacedan the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Wed cal Exercises must be notified as 1 ☐ Yes 2 1 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code United States 20906 3398 Gleneagles Drive #1C Funeral death 14. Race - Amarican Indian, Bleck, Whita, atc. 12. Was Dacedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 2 should be filed within 72 hours after of and Mentel Hygiene. 1 X Yas 2 No 1960− If Yes, Giva Yaer or Detes: 1962 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 Steamfitter Air Conditioning 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Nama (First, Middla, Last) Harriett Norris Robert E. Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Io n 11406 Soward Drive, Kensington, Maryland 20895 Barbara Cottrell/Sister 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition Jan. 29, 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 2000 Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** ACTECHO SCIENCTIC CHLOIOUTSCULA DISENTE Immediata Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner physician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): certificate be exec Box 68760. Physician/Medical that Initiated avants Dua to (or as a consequance of): resulting in daeth) Last 88 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown SIP STROKE Division of Vital Records, à 24a. Was an autopsy performed? 24b. Ware autopsy findings aveilable prior to Completed completion of cause of death? page 2 has 25. Was casa rafarred to madical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 Residence 6 ☐ Othar (Specify) 1 Yas 2 No 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? i or Attending P safter death. Certification: 5 Panding invastigation 1 Yes 2 No 2 Accidant 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar OME D15736

State Registrar

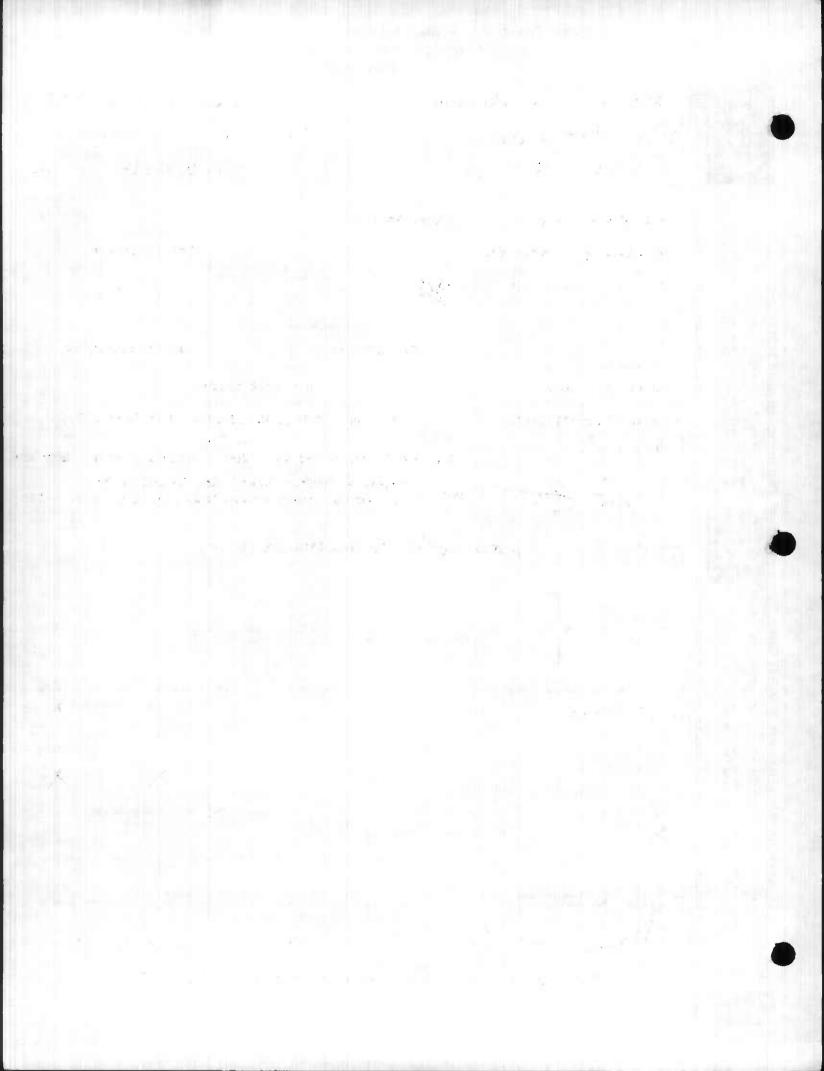
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31. Date filed (Month, Day, Year) 2000 32. Degistrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I. MARGOUS, MO. 11125 ROCKULLE PIKE, ROCKULLE, MO 20852

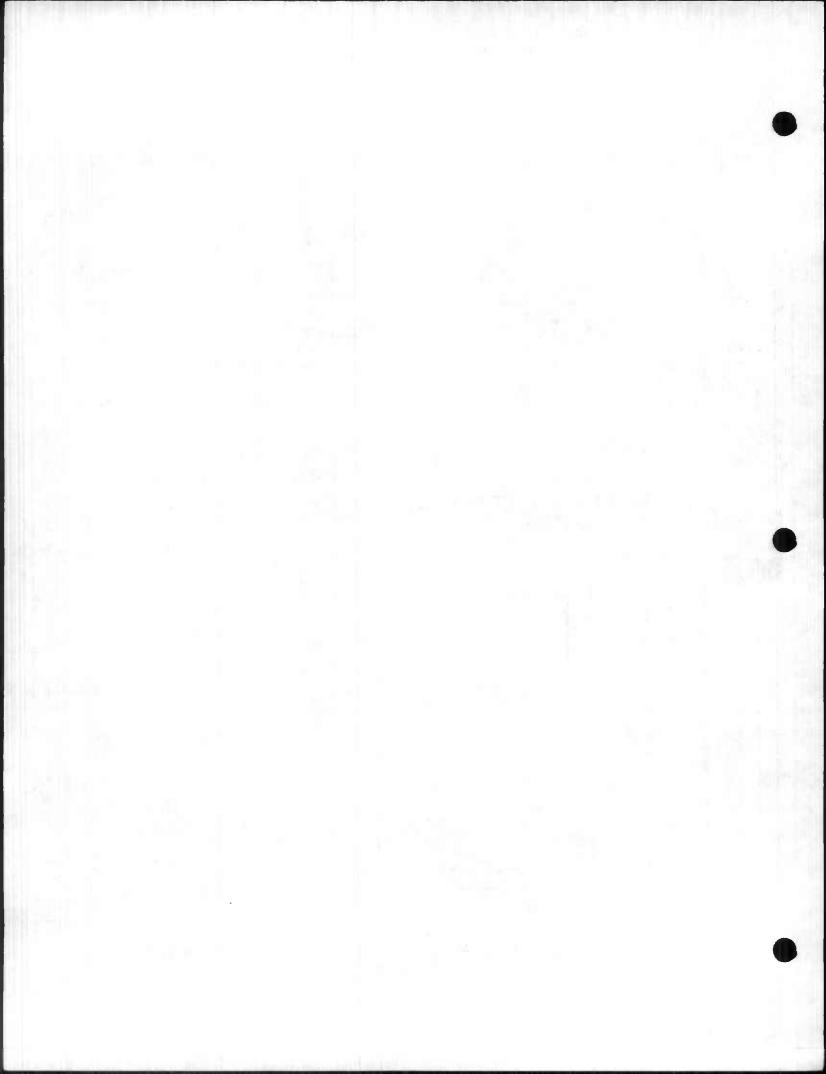
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State of Maryland / Department of Health and Mental Hygiene 00 04438

| Decedent's Name (First, Middle See See See See See See See See Se | | | | | | | | Reg. | | | |
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| 4. C. 10b. 11-1-12-12-12-12-12-12-12-12-12-12-12-12 | e, Last) | | | | | | | of Death | 0 | | Time of Death |
| An C-184 . 61 114 | Rose | | Г | uby | | | Jan | dary : | 30, 20 | 000° | 4:15 PM |
| 4e Facility Name (If not institution | | oer) | | Judy | | 4b. City, Town | , or Location o | Death | 4c. County | of Death | |
| Willwood Nursi | na Uoma | | | | | o + b o a d | | , | lantaa | | |
| Hillwood Nursin | | Age (In yrs. la | st birthday) | If Unde | r 1 Year | Bethesd If Under 24 | Hrs. 8 Date | of Birth | lontgo | 9 Rinholace | (State or Foreign |
| 010-07-0630 | 1□ M 20 F | 85 | Yrs. | Months | Days | Hours | Min. (Mor | th. Day. Yo | 1914 | Country) | on, MA |
| Usual Residence of Decedent | | | | | | | | | , -, -, | 2000 | |
| 10a. State 10b. County | | 10c. City, | Town or Loc | ation | | | | | | 10d. | Inside City Limits |
| MD Montgo | omerv | Beth | esda | | | | | | | | 1 ☐ Yes 2 ☐ No |
| 10e. Street and Number | | | | 104 79 | p Code | | | 100 | Citizon of V | /het Country? | |
| 5137 West Bard | A110 2110 | | | | 20816 | | | log. | | riibi Cooriiry i | |
| | | | | | | | | | USA | | |
| 11. Marital Status | 12. Was Decede Armed Force | ps? | 13. W | Yes, spe | dent of F cify Cubi | lispanic Origin an, Mexican, P | ? (Specify Yes uerto Rican, e | or No- lc.) | | - American I k, White, etc. | ndian, |
| 1 Never Merried 2 Marri | ied 1 Tes 24 | № No | 1 | ☐ Yes | 2XXVo | Specify: | | | Specify | White | |
| 3Ã Widowed 4 □ Divorced | Year or Date | es: | | | | | | | | white | |
| 15. Decedent (Specify only highes | r's Education at grade completed) | | 16a. Decede (Give k | ent's Usu | at Occup | ation during most of | working | 168 | . Kind of Bu | siness/Indust | У |
| Elementary/Secondary (0-12) | College (1-4 | or 5+) | lite. D | ONOT | ise <i>retire</i> | 0) | | | | | |
| 12 | | | Book | kkee | per | | | | Roofin | 0 | |
| 17. Fether's Name (First, Middle, L | Last) | | | | | | Name (First, I | | | Θ) | |
| Harry Hurwitz | | | | | | Bes | sie Wo | lfowi | tz | | |
| 19e. Informant's Name/Relationsh | hip (Type, Print) | | 19b. Mailing | Addres | s (Street | and Number o | r Rural Route | Number, C | ity or Town, | State, Zip Coo | de) |
| Martin Duby - S | Son | | 5137 | 7 Wes | st Ba | ard Ave | nue B | ethes | da, MI | 2081 | 6 |
| 20a. Method of Disposition | | 20b. Pla | ce of Dispos netery, crem | ition (Na | me of | | Feb. | 200 | Location - | City or Town, | State |
| 1 Burial 2 Cremation | | 916 | | | | | | | D | 4 D- | m |
| 4 Donation 5 Other (Sp | ** | ELE | | | | | en 200 | | | | ach, FL |
| 21. Signeture of Funerel Service L | Licensee | | 0 22. | Name e | na Adare | ss of Facility | Metrop | olita | n Fune | eral Sy | c., Inc |
| Jaren | 1.100 | Ado (| 55 | 17 V | ine | St. Ale | xandri | a. VA | 22310 |) | |
| 23a Part1. Enter the disease, or shock, or heart tailure. List of | complications that cau | sed the death. | Do not ente | r the mo | de of dyir | ng, such as ca | rdiac or respira | tory errest | | Ap | proximate erval Between |
| SHOOK, OF HOUSE CARGO. LIST | ony one cause on eac | 41 11110. | | | | | | | | On | set and Death |
| Immediate Cause (Final | Sa | psis | | | | | | | | | |
| disease or condition resulting in death) | a | 215 00 00 | | 717.5 | | | | | | 1 | |
| | For | Due to (or a | as a consequ | ience of) | : | | | | | 1 | |
| | b | | | | | | | | | - | |
| Sequentially list conditions, if any, leading to immediate | | Due to (or a | is a consequ | ience of) | : | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | с | | | | | | | | | 1 | |
| that initiated events resulting in death) Last | | Due to (or a | s a consequ | ence of): | | | | | | | |
| | d | | | | | | | | | t | |
| | | | | | | | | | | | |
| | ns contributing to deat | h but not result | ing in the un | 4-4-5 | | | | | | | |
| Part II. Other significant condition | | | | genying (| cause giv | en in Part I. | 231 | o. Did toba | cco use cor | tribute to the | cause of death |
| | | | | deriying (| cause giv | en in Part I. | 231 | | cco use cor | tribute to the | |
| Part II. Other significant condition Dementia | | | | denying | cause giv | en in Part I. | 231 | | | | |
| | | | | derrying (| cause giv | en in Part I. | _ | 1 ☐ Yes | 2 ☐ No utopsy | 3 Probabl | y 4 Unknow |
| | | | P = | oenying (| cause giv | en in Part I. | _ | 1 Ves | 2 ☐ No utopsy | 3 Probabl | y 4 Unknow |
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| Dementia | | | | oerrying (| cause giv | | 248 | 1 Ves | 2 ☐ No utopsy | 3 Probabl | y Unknown autopsy tindings ble prior to ation of cause th? |
| Dementia 25. Was case referred to medical examiner? | Hospital: | | | | | 26. Place of | 24a Death (Check | 1 ☐ Yes . Was an a performed 1 ☐ Yes . only one) | 2 No utopsy 17 | 24b. Were availat comple of deal | y 4 Unknown autopsy tindings ale prior to etion of cause th? |
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| Dementia 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Detty 5 Pending investig | Hospitat: 1 Inp 28a. Date of I (Month, | niury 2 | 8b. Time of | 3 D | OA Oth | 26. Place of | Death (Checking Home 5 D | 1 Yes Was an a performed 1 Yes only one) | 2 No utopsy 1? 2 No e 6 Oth | 3 Probable 24b. Were availated completed for deal | y 4 Unknown autopsy tindings ale prior to etion of cause th? |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year FEBRUARY ELEANOR BARDELL DUNN 3, 2000 10:45 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SPRING LAYHILL CENTER/GENESIS HEALTHCARE MONTGOMERY SILVER If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 M 2 XX Yrs. MAY 31, 78 521-12-8584 1921 COLORADO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 N No MARYLAND MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13114 IDEAL DRIVE 20906 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes ZONO
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify. Specify 3 □ Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 OFFICE MANAGER DENTAL OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SHERMAN WALTER BARDELL EVA FLANNERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA M. DISNEY - DAUGHTER 13114 IDEAL DRIVE, SILVER SPRING, MARYLAND 20906 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 CCremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CREMATORY 2-4-00 BRENTWOOD, MARYLAND 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 Part1. Enter the diseas shock, or heart feilure. complications that caused the teath. Do not enter the mode of dying, such as cardiec or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Deeth Vneumonia Immediate Cause (Final work disease or condition resulting in death) dosmi chue dislase 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ⊠ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

natural", or items 23a or 28a-f show ofices Examiner must be notified at

be filed within 72 hours after death to that Hygiene.

I dother than "natural", or flame 234 avant, the Medical Exercises from

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic avam

21215-0020

aitimore, Maryland

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Funeral

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Completed

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Maryland

with the

burial-transit pue physician s the buria 88 been signed by the a ahould be detached t page 2 certificate funeral director, this

Examiner The law requires that the death certificate be axecuted Box 68760. P.O. Records, of Vitai Physician: Certification: To Attending Division after death. 6

Physician/Medical þ Completed Be

27. Manner of Death

1 SNatural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

within 24 hours after de To the Funeral Directo completely lilled in by th 10

Medical

Hospital

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0

State Registrar

5 Pending

investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number 382

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

MD

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

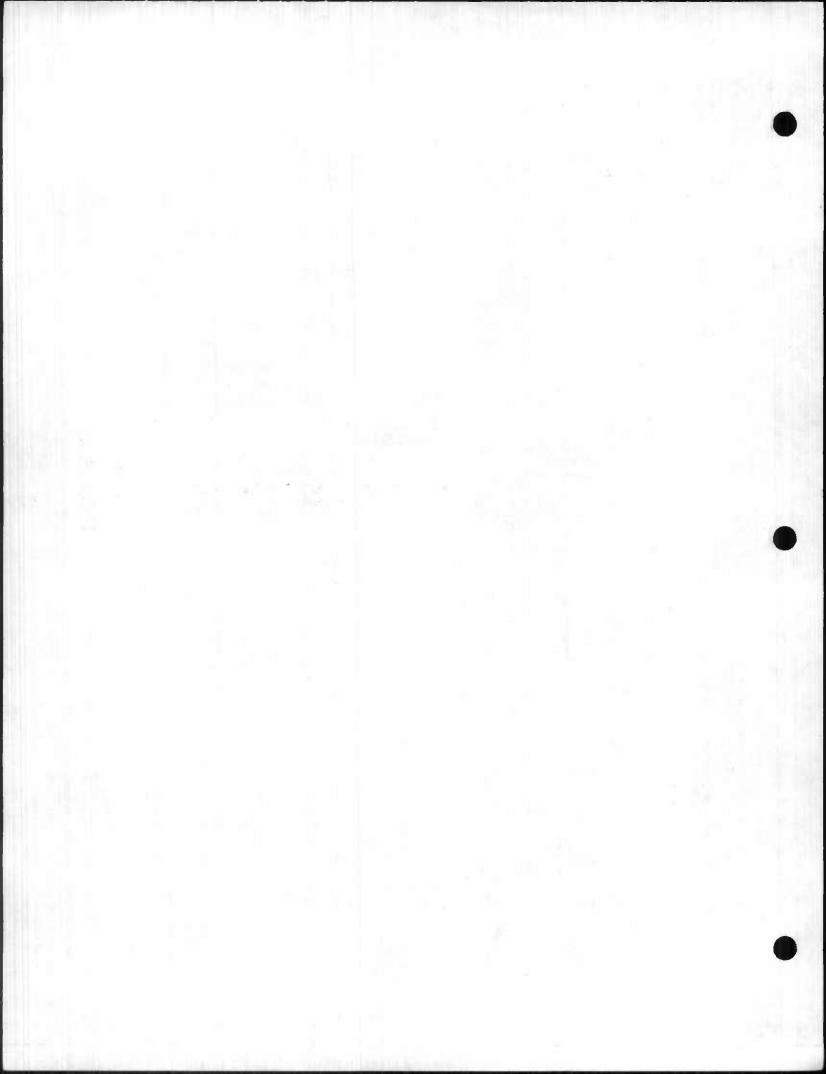
30. Name and address of person who completed cause of death (Item 23g) (Type, Print)

Research BLVD Suite 340 Rockville D. A MENDHIRATTA . 2401

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year) FEB 04 2000

32. Fjegistrar's Signature

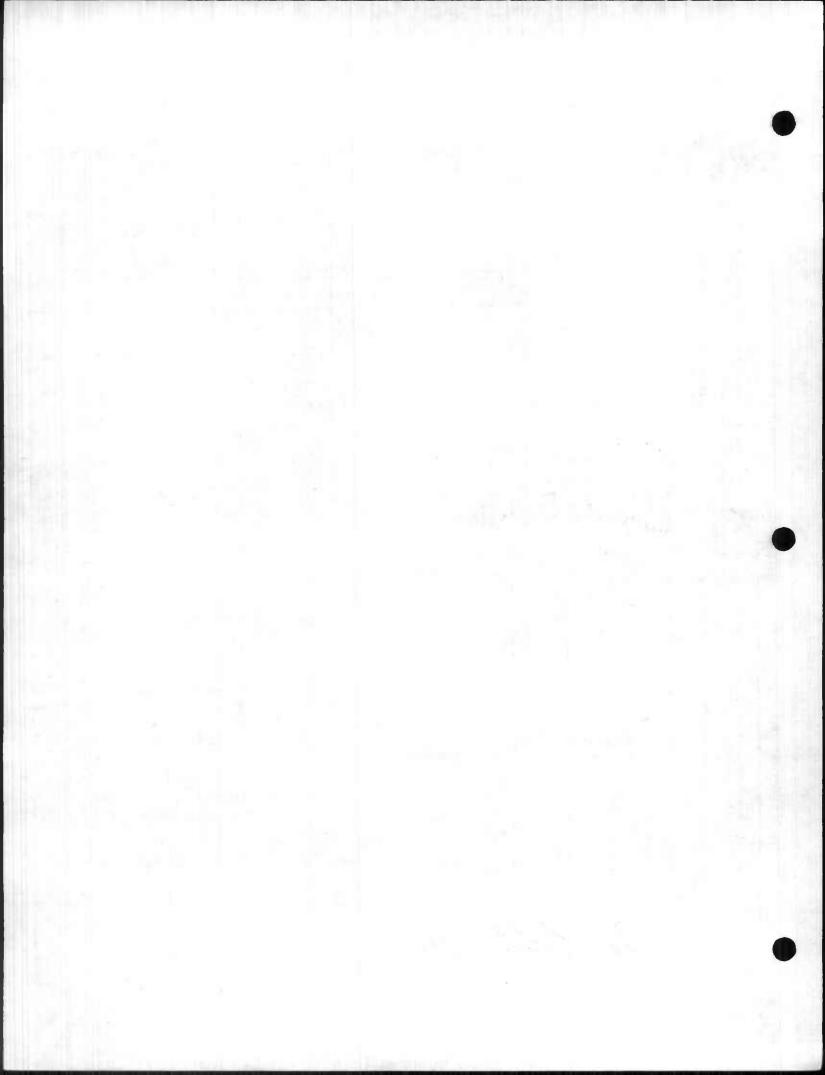


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State of Maryland / Department of Health and Mental Hygiene | | n le le le n Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Harry M. Dyson January 31, 2000 5:50 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10XM 2□ F 220-05-1296 Yrs. 80 April 13, Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location notified at 1 Yes 2 No Maryland | Montgomery Directo Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 10440 Democracy Lane 20854 United States Berns 23a Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No World If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status than "natural", or lien the Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: War II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. other than Elementary/Secondary (0-12) College (1-4or 5+) Director of Research Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Meiden Surname) Pages 1 and 2 should be fill trinent of Health and Mental H lant: If flem 27 is marked off Be Harry M. Dyson, Sr. Alice Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other trau 10440 Democracy Lane, Potomac, Maryland 20854 Kathryn M. Dyson/ Wife 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Feb. 3, 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2000 Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/ 21. Signature of Funerel \$ Rockville, Inc. 300 West Montgomery Avenue, M00689 KOCKVILLE, Maryland 208 months of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, trailure. List only one ceuse on each line. Rockville, Maryland 20850-2805 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Pnuemonia Examiner Due to (or es a consequence ot): Examiner physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ot): Box 68760. Physician/Medicai Due to (or as a consequence of): 65.00 980 P.O. Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Stasis Ulcer Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed Cerebrovascular Accident page 2 s The 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Attanding 1 ⊠Neturai 5 Pending • Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 8 Hospital edical 15 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho. To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier 29c. License number D20516 8+1 January 31, 2000 and address of parson who completed cause of death (Item 23a) (Type, Print) Joel R. Schulman, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State FEB 02 2000 oorks Registrar

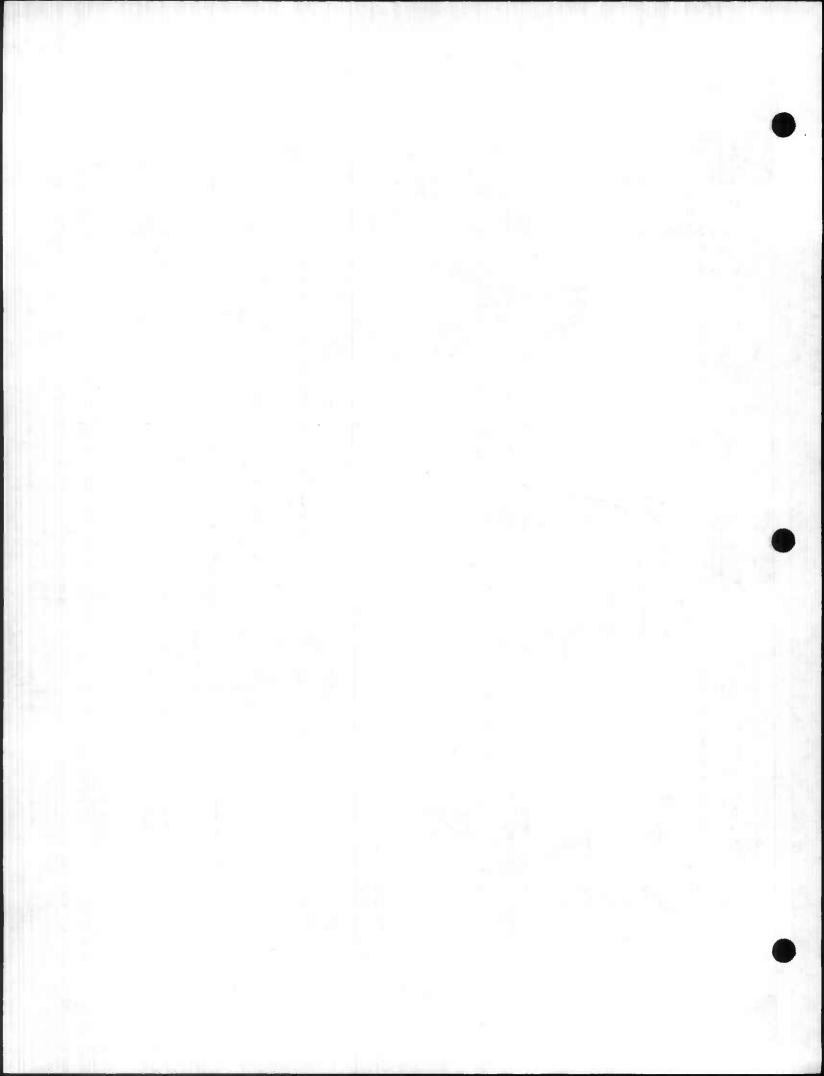
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State of Maryland / Department of Health and Mental Hygiene 00 044

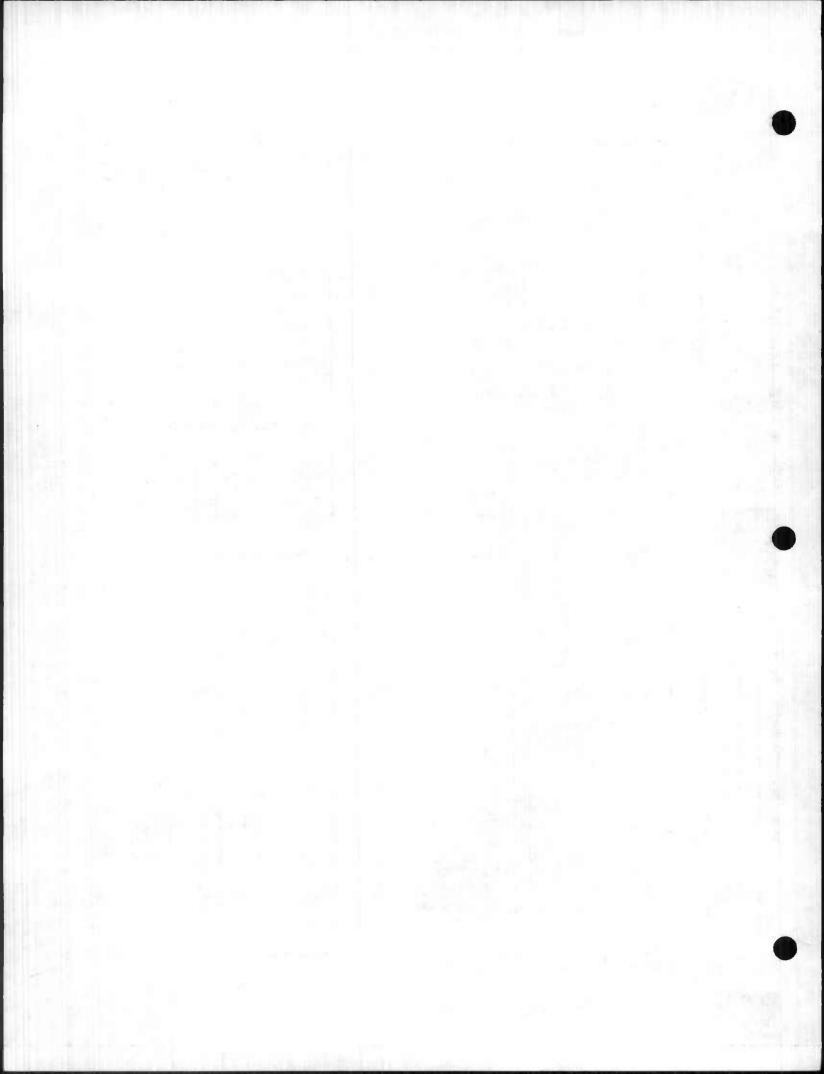
| | | | Certificate | e of Death | Re | eg. No. | 04441 | |
|--|---|--|---|---|-----------------------------------|--|---|--|
| | 1. Decedent's Name (First, Middle, Last | 0 | | | 2. Dete of Deat | h | 3. Time of Death | |
| Physician | MARIAN LOU | JISE DeLAU | TER | | JAN. 19 | , 2000 Yes | 3:30pm | |
| /Medical Examiner | 4e Facility Neme (If not institution, give | | | 4b. City, Town, or L | ocation of Death | 4c. County of D | eeth | |
| | 17509 Harbaugh Va | allev Road | | Sabillasy | ville | Freder | ick | |
| Funeral | 5. Sociel Security Number 6. Se | 7. Age (In yrs. la | ast birthdey) If Under Months | | 8. Dete of Birth | 9 1 | Birtholace (State or Foreign | |
| Director | 215-26-2200 Usuel Residence of Decedent | ^{□M 2} TF 75 | Yrs. | Deys Frours Mills. | July 18 | , 1924 | Country) | |
| /land | 10a. Stete 10b. County | 10c. City, | , Town or Location | | | | 10d. Inside City Limits | |
| Mar 10 | Maryland Frederic | ck Sab | illasville | | | 1 ☐ Yes 2 ☑ No | | |
| ith the Main or 28a-fa | 10e. Street and Number | | 10f. Zip | Code | 1 | 0g. Citizen of What | Country? | |
| death with the Maryland rms 23a or 28a-f show rmast be notified at | 17509 Harbaugh Va | alley Rd. | | 21780 | | USA | | |
| or Re | 11. Mentel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Detes: | | ent of Hispanic Origin? (Sp fy Cuben, Mexican, Puerto No Specify: | pecify Yes or No- Pican, etc.) | 14. Raca - A Bleck, W Specify: W | | |
| n 72 hours aft | | | 16a. Decedent's Usuel | Coupation | | 16b. Kind of Busine | | |
| be filed within 72 ho tal Hygiene. I other than 'natur went, the Magnetal | (Specify only highest grad | | (Give kind of work | k done during most of worl e retired) | king | 100. Kind of busine | samoustry | |
| d within 7 giene. | Elementery/Secondery (0-12) | College (1-4or 5+) | Homemake | | | Own Ho | me | |
| Hed Had | 17. Father's Neme (First, Middle, Last) | | | 18. Mother's Nerr | e (First, Middle, M | deiden Sumeme) | | |
| | | Valentine | | Grace | | | Bollinger | |
| 12 should h and Men is marke traumatic | 19e. Intormant's Neme/Reletionship (T) | | 19b. Meiling Address | (Street and Number or Ru | ral Route Number | City or Town, Stat | e. Zio Code) | |
| 2 6 6 6 | Edwin DeLauter (| | | | | | le, MD 21780 | |
| | 20a. Method of Disposition | | ece of Disposition (Nem- metery, crematory or of | | | 20c. Location - City | | |
| Pages 1 and the state of Heart of Heart of Heart of Heart of Heart or other or other heart or ot | 1 Buriel 2 Cremetion 3 F | Jennovei Irom Stete | | l l | 122100 | Thumant | Manuland | |
| partine P portant y injury | 4 Donation 5 Other (Specify) 21. Signeture of Funeral Specifical Const | | Ridge Ceme | Address of Fecility | /22/00 | Inurmont, | Maryland | |
| pemit. Pag Department Important: Ii any injury o | 21. Signature of Funeral Spirital Spirit | | Robert | E. Dailey & | Son, P. | Α. | | |
| 40246 | 1/ | | | Main St., T | | | 3 | |
| | 23e. Part. Enter the diseese, or complement of the complement feilure. List only of | icetions thet caused the deeth. ne cause on each line. | . Do not enter the mode | of dying, such es cardiec | or respiretory arre | est, | Approximete Intervel Between | |
| Physician | Canada and | | | , | | | Onset end Death | |
| /Medical Examiner | Immediate Ceuse (Final disease or condition | Motastar | tetra | Q. tronial | 0018 | | 15 mas | |
| 40 | resulting in deeth) | Due to (or | as a consequence ot): | | 1 | | | |
| i e | | Calcina | sma-K | ght weigh | TEL So | acc. | , | |
| and -tran | Sequentially list conditions, | Patte Due to for | es a consequence of): | 2 6/0 | dalas | 4 | | |
| The law requires that the death certificate be axecuted to have been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner. | Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Carcina | 10 real | 0001 ly 9 | " april | tated | 112 mos. | |
| the the the the the the the the the the | thet initiated events resulting in deeth) Last | Due to for | es a consequence of): | 1 7 . | 00 | 7 | | |
| ing p e as | | d | | | | | | |
| as that the death certigned by the attendin be detached for use. by Physician/M | | J | | | | | | |
| ras that the designed by the all be detached for by Physic | Pert II. Other significant conditions con | ntributing to death but not result | Iting In the underlying ca | use given in Pert I. | 23b. Did to | bacco uss contrib | ute to the cause of death? | |
| at the diby the etache | Atto in O O' /- | · 11. +2 00 | | | 1 🗆 Y | 88 28 No 3 | Probably 4 Unknown | |
| b ed by | 1111100 12101 | 2./10/100 | | | | | | |
| The law requires the tast has been signed page 2 should be Completed by | 1/10/100 | is last B | | a altal | 24a. Wes e parforr | | lb. Wera autopsy tindings available prior to | |
| by re 2 sh 2 sh 2 sh | 1 works | & Coff to | more | for itsal | | | completion of cause of deeth? | |
| he is he ga | to inf | rescoiler | acavo | | 1 P | s 2 X No | 1 ☐ Yes 2 ☐ No | |
| entifica octor, p | 25. Was case referred to medical | | | 26 Piece of Dee | th (Check only on | (a) | | |
| Attending Physician: The law in death. ector: After this certificate has by the funeral director, page 2 ification: To Be Comp | everniner? | Hospitel: | ER/Outpetient 3□ DO | Other | | ence 6 Other (5 | Specify) | |
| Physical area | 27. Menner of Death | | | Sc. Injury at Work? | | ow injury occurred | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| ding th. After | 1 Neturel 5 Pending investigation | (Month, Day Year) | Injury | Work? 1 ☐ Yes 2 ☐ No | | | | |
| or Attending Physician: 1 safer death. Director: After this certifical in by the funeral director, pertification: To Be C | 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Injury - At hon | ne, term, street, tectory, | office | | | r Rurel Route Number, | |
| tal or Attending P rs after death. al Director: After t ed in by the funare Certification: | 4 Homicide | building, etc. (Specify) | | | City or Town | n, Stete) | | |
| To the Hospital or J within 24 hours after To the Funeral Direct Completely filled in b Medical Certi | | sician: To the best of my know ner: On the bests of examinetic end menner steted. | | | | | | |
| ithin of the omple omple | 29b. Signeture end title of certifier | one mainer eleter. | 290 | License number | 2 | 9d. Date signed (M | onth, Day, Year) | |
| F 3 F 8 | 2 1 / 1 | 1 0 | 4 | | 2 N | | | |
| | Donito KA | supt to | MIELDO | 1440 | 5/ | January | 21, 2000 | |
| | 30. Neme end siddress of parson who co | ompleted cause of death (Item : | 23a) (Type, Print) | | , | | | |
| | Bonita Portier, | | | urmont, MD 2 | 1788 | | | |
| State | 31. Dete filed (Month, Day, Year) | 32. Registrers Signet | ure 6 | / | | | | |



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** SHIRLEY Α. 18, 2000 January 12:30 P.M. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8431 Walter Martz Road Frederick Frederick If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 X F Director 577-20-6581 74 Oct. 2, 1925 Washington, DC Usuai Residence of Decedent The Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Director 28a-f Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be r b 8431 Walter Martz Road 21702 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White 'n Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) federal Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) government secretary Baltimore, Maryland 17, Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be i Copartment of Health and Mental I Important: If Nem 27 is marked of any Injury or other traumatic eve John Varoutsos Ann Pappas 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8431 Walter Martz Rd., Frederick, MD Wallace Dow/ husband 21702 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 1/21/00 Frederick, Maryland 22. Name end Address of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Funerel Service Licensee Kreh garguela 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Finel d disease or condition resulting in deeth) 11-060. Examiner Due to (or es a consequence of): Examiner 9 496 x C- P-15107 bunal-transit The law requires that the death certificate be asscuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physician s the buna Box 68760. Physician/Medical Due to (or es a consequence of) 98 980 P.O. Pert tt. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 68 þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 certificate 1 ☐ Yes 2 D No 1 ☐ Yes 2 ☐ No Vital or Attending Physician; director. Be 25. Was case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of After this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 D Neturei 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital To Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier Medical completely (Check only one) within 2 4 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L. my 1214636 19. 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Gregory P. Rausch / 501 W. 7th Street, Frederick, MD 31. Dete filed (Month, Dey, Year) 2 0 2000 32. Registra's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04643 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death JANUARY 29, ROBERT LEROY **DEVILBISS** 2000 5:55 AM 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 3, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1⊠M 2□F Yes 212-14-6404 86 1913 Maryland Usuei Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maruland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 101 Tippin Drive United States 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Owner/Operator Grocery Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willis R. Devilbiss Edna G. Geesey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy A. Stull / Daughter 5742 Butterfly Lane Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Feb. 4 ☐ Donetion 5 ☐ Other (Specify) Blue Ridge Cemetery 2000 Thurmont, Maryland lature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death arkin chise . Desens Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobecco use contribute to the cause of death? 200 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 26. Place of Death (Check only one)

Physician /Medical €xaminer

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vitai Records.

or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

or 25a-f show

Berra 23a

natural, or

Hyglene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth-any Injury or other traumatic event

Director

Funeral

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Completed

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the Maryland

Illed within 72 hours after

altimore, Maryland 21215-0020

Examiner Physician/Medical ρV Completed Be

sician and burial-transit attending physician for use as the buris signed by the ald be detached for page 2 funeral director, Certification: To To the Hospital or Atte-within 24 hours after del To the Funeral Director completely filled in by the edical

has

this

Affer

death.

after deatl

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

5 Panding

investigation 6 Could not be determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signeture end title of Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

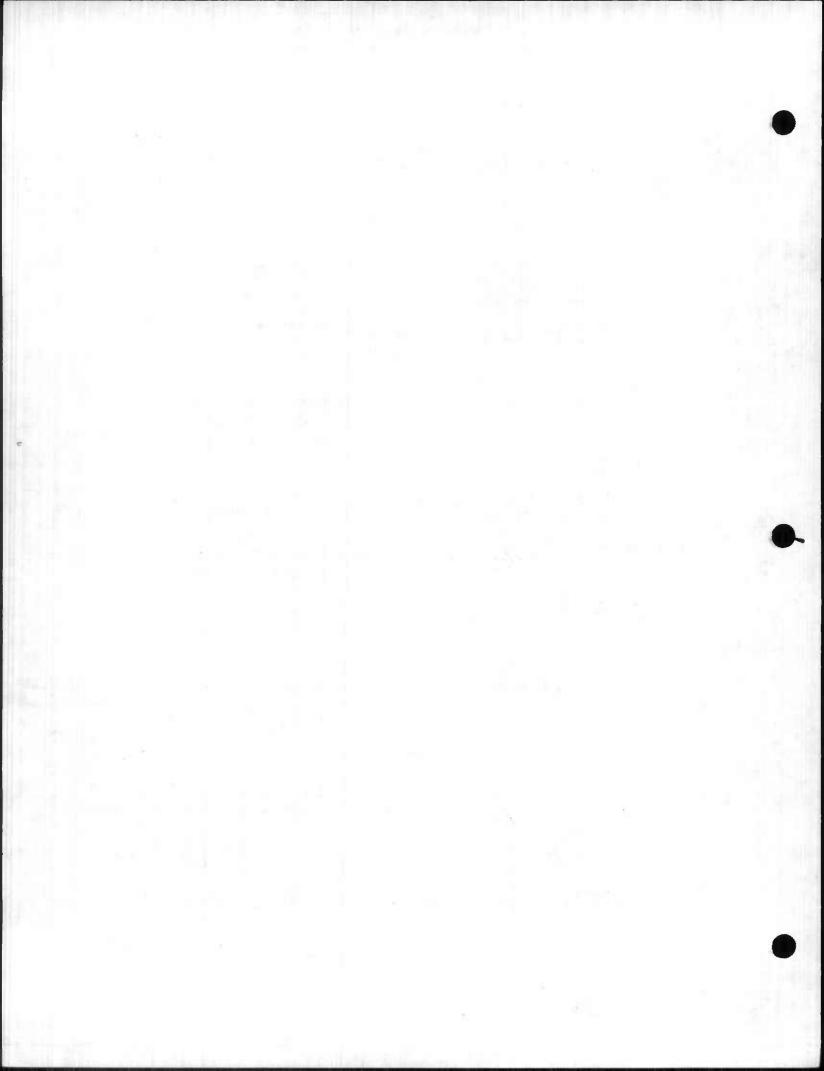
Robert L. Kaufmann, MD

300 West 9th Street

Frederick, MD 21702

000

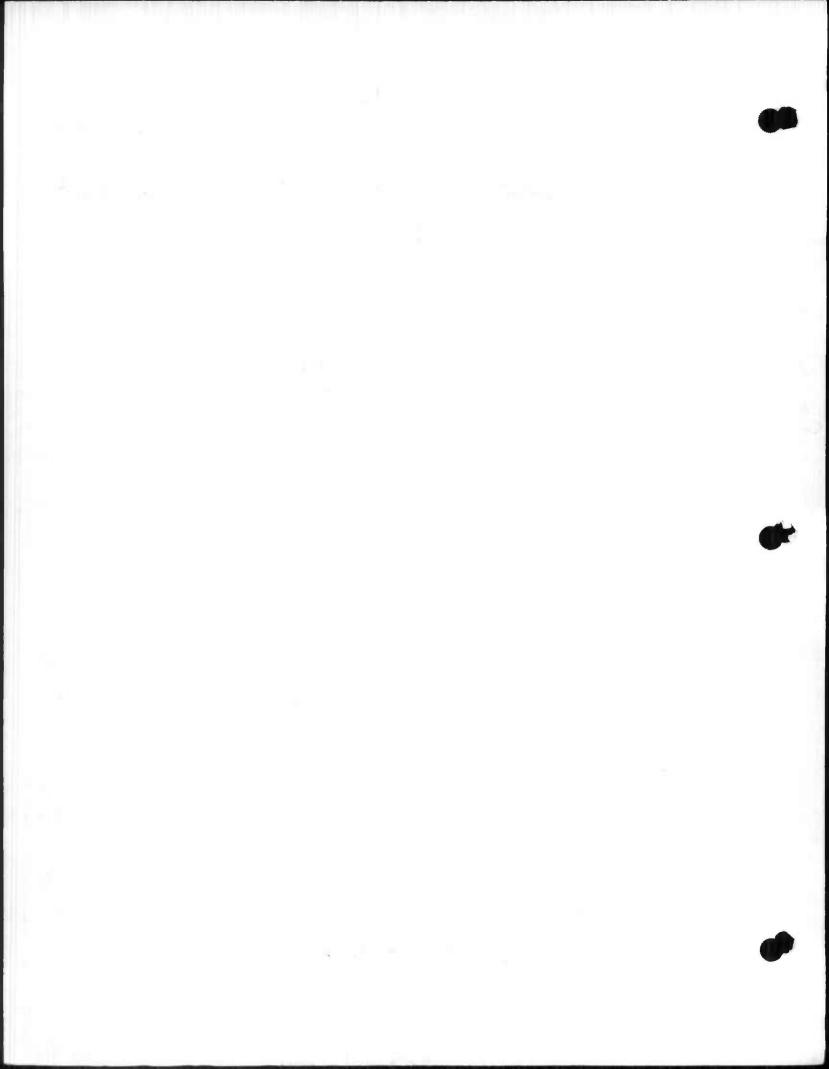
State Registrar



| BAL | er death. |
|---|---|
| | hin 24 hours after death. |
| | hin 24 |
| 20 | d with |
| 100 | execute |
| 5 | Pe |
| ISION OF YILAL RECORDS, P.O. BOX 68/600 | he law requires that the death certificate be executed within |
| , | death |
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| 7111 | reguires |
| 3 | WE |
| 1 | The |
|) L A | YSICIAN |
| - | H |
| 2 | TENDING PHYSICIAN: Th |
| | |

| HE HOSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | MRECTOR: A | ed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | DRTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|--------------------|--|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law | MRECTOR: After the | ours after death v | IMPORTANT: If Item 28 is marked, or Item 23 | |

| _ | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | MENTAL HYGIEN | | 0 1 1 1 1 | |
|---------------|--|---|-----------------------|-----------------------------|--------------------|--|-----------------|---|--|
| 7 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| - | Margaret | Arissa | | Dryden | | Sansary D | 71 - | "404. 6 CO | |
| | 4. SOCIAL SECURITY NUMBER | | n yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | |
| | 218-30-0838 9e. FACILITY NAME (If not institution, give st | 1 □ M 2 A F 86 | YRS. | | | 09/26/191 | 3 C | anada | |
| Œ | 0 1 00 | | | 7 | R LOCATION OF E | | | Y OF DEATH | |
| DIRECTOR | RESIDENCE OF DECEDENT | lnor | | Trinces | 2 Hu | ine | _ 30 | merset | |
| RE | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | |
| | Maryland Some | rset | Pr | incess A | | | | 1 YES 2 NO | |
| FUNERAL | | | | 10f | . ZIP CODE | | 10g. CITIZER | N OF WHAT COUNTRY? | |
| N. | 11974 Edgehill Te | PPACE 12. WAS DECEDENT EVER IN | II a ADMED | 12 988 050 | 21853 | ANIC ORIGIN? (Specify Yes | | USA | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | II yes, spi | cify Cuben, Maxic | can, Puerto Rican, etc.) | 6 OF NO- 14 | RACE — American Indian, Black, Whita, atc. | |
| BY | 3 Widowed 4 Divorced | | | 1 1 123 | 2 pmc space | ary: | | Specify: White | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | ATION completed) | (Give kind of | USUAL OCCUPATIO | N st of working | 166. KIND OF BU | SINESS/INDUS | | |
| Ž. | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT u | se retired.) | | | | | |
| N N | 12 17. FATHER'S NAME (First, Middle, Last) | 3 | Regist | ered Nur | | Medica | | | |
| | Neal Armstrona | | | | | IAME (First, Middle, Maiden | Surname) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | | eth Kehoe I Route Number, City or Tow | n State Zio Co | order) | |
| 2 | Julia Ford | | | | | cess Anne. | | | |
| | 10a. METHOD OF DISPOSITION Burial 2 Cremation 3 Ramo | | PLACE AND DATE | OF DISPOSITION /Na | me of | DATE 20c. LO | CATION — City | y or Town, State | |
| | 4 Donation 5 Other (Specify) | St. | etery, cremetory or o | s Enisco | pal Cem | 2/4/2000 | Prince | ess Anne, Md | |
| | SIONATURE OF FUNERAL SERVICE LICE | LYSEE . | | 22. NAME AN | D ADDRESS OF F | ACILITY | | 21853 | |
| 1 | Hinman Funeral Home 21853 11673 Somerset Ave., Princess Anne, Md. | | | | | | | | |
| | PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | |
| 4 | IMMEDIATE CAUSE (Final | | | | | | | Interval Between Onset and Death | |
| | disease or condition resulting in death) | DUE TO (OR AS A | CVA | e L | Hen | riplegi | 2 | 8 days | |
| | | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| CERTIFICATION | Sequentially list conditions, | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| CAT | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| Ė | CAUSE (Disease or injury that initiated events | OUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| E | resulting in death) LAST |) | | | | | | | |
| AL C | PART ii. Other aignificant conditions | contributing to death bu | it not resulting | in the underlying | cause given in | n Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | |
| S | arterioseler | Lie Card | iovas | euler I | Dina | PERFOR | | AVAILABLE PRIOR TO COMPLETION DF CAUSE | |
| MEDIC | Chronie Brain | Simbeon | e. Dem | enta. | Hapey | Lean 1 TYES 2 | 52 NO | OF DEATH? 1 ☐ YES 2 5€ NO | |
| ž | DID TOBACCO USE CONTR | BUTE TO CAUSE OF | DEATH YE | S NO | UNCERTA | IN 🗆 | | 1 2 1 2 1 30 110 | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 6. PLACE OF DEA | TH (Check only one) | | | | | |
| YSI | 1 TES 2 NO | 1 - Inpatient 2 - ER/Outpe | ntient 3 🗆 DOA | OTHER: 4 12 Nursing Home | 5 🗆 Realdence | 6 Other (Specify) | | | |
| F | 27. MANNER OF DEATH 1 X Natural 5 Pending | (Month, Day, Year) | 28b. TIM | URY WO | RK? | 28d. DESCRIBE HOW I | NJURY OCCUR | IED | |
| BY | 2 Accident Investigation | 200 BLACE OF IN HIP | At here is to an | | ES 2 NO | | | | |
| GE. | 3 Suicide 6 Could not be 4 Homicide determined | 28e, PLACE OF INJURY building, etc. (Special | fy) | afreet, factory, office | | 281. LOCATION (Street City or Town, State) | and Number or i | Rural Route Number, | |
| LE I | 29a. CERTIFIER | | | | | 7 | _ | | |
| COMPLETED | (Check only | ZIAN: To the bast of my knowle | | | | | | ause(s) and manner as stated. | |
| | DRILEBNATURE AND TITLE OF CERTIFIER | . On the basis of Examination | and/or investigatio | m, in my opinion, de | | | d due to the c | ause(a) and manner as stated. | |
| BE | The same of the sa | Rill. | no.5 | 2 | 29c. LICENSE NU | | | IGNED (Month, Day, Year) | |
| 2 | 10. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH OTEM 27) (Town | Print) | y ha. | 505 | 1- | -31-2000 | |
| | GREGORIO M. BE | | | | CODV . | DR. SALISB | | 110 01901 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRÁR'S SIGNA | TURE | CHINAD | | VK., ZALID D | MKY, | MV 21801 | |
| | FFR 0.4 200 | 1 hours | 1 4 | | | | | | |
| | | | 10. | poporte | 2 | | | OHMH-16 Rev 1/89 | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOYCE DEVAUX JAN. 29,2000 6:30AM /Medical 49 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD. WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2XF 216-64-8724 Director MD 12-07-Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ahow must be notified at MANOK:n 1 ☐ Yes 2 况 No Funeral Director OMERSE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 96 21836 intAino PD Hems. 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, Whita, etc. 11. Maritel Stetus r then "natural", or iten filed within 72 hours after Yes 2 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Black Completed by Specify: 3 Widowed 4 Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Hygiene. Collega (1-4or 5+) hespeake atified Keheb Nuising Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be finent of Heelth end Mental I inter 27 is marked of salph DEVAUX Moody EIA 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moody FIETA Vincess MD 21853 AOO C 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City of Town, Steta Department of important: If its any injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Spring Compley

22. Name and Address of Fadility 2-7-00 4 ☐ Donation 5 ☐ Other (Specify) NOTZAT 21. Signeture of Fanaral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21853 Ave. Princess 45 Approximate Interval Between Onset and Death **Physician** /Medical fmmediate Ceuse (Finel disease or condition rasulting in death) Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es e consequenca of): signed by the attending p Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? certificate has 1 Yes 2 No 1 Yas or Attanding Physician: funeral director, 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 ☐ Mursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2√ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of fnjury 28c. Injury at Work? 1 DNatural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stated. the th 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

FEB 0 2 2000 **DHMH 16 Rev 6/95**

WILLIAM ROBINS,

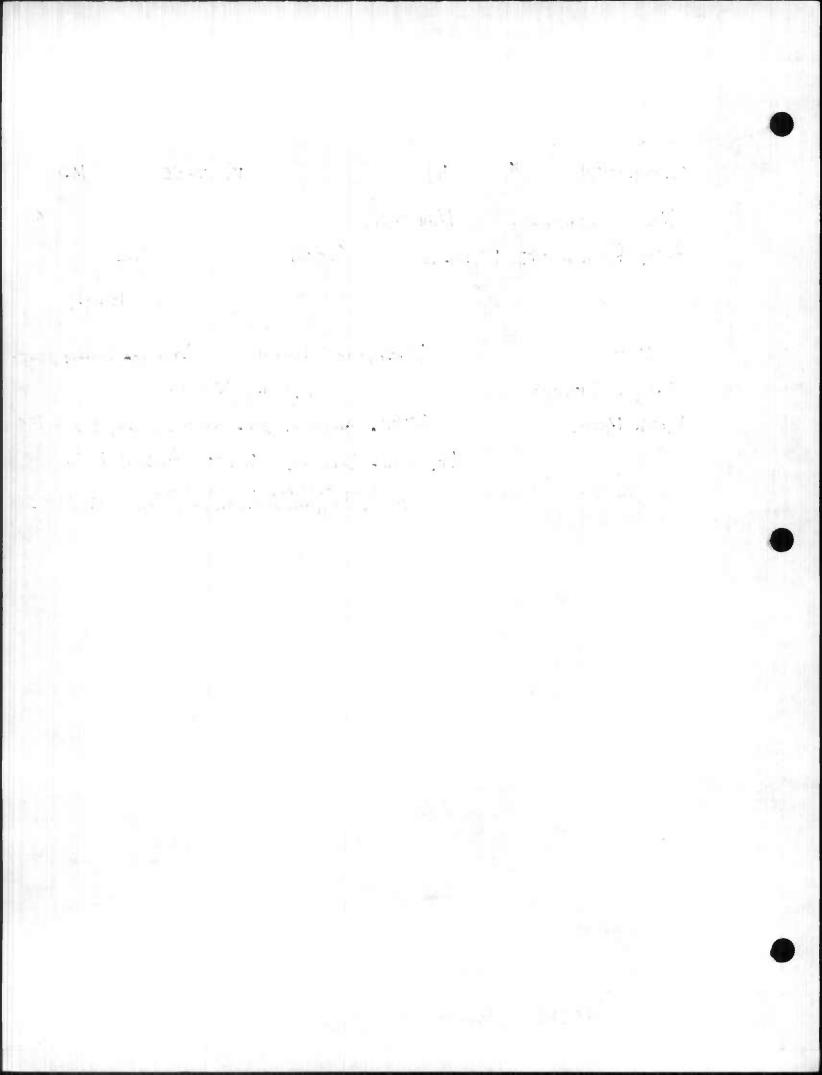
31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

ORIGINAL

1104 HEALTHWAY DR., SALISBURY, MD. 21804

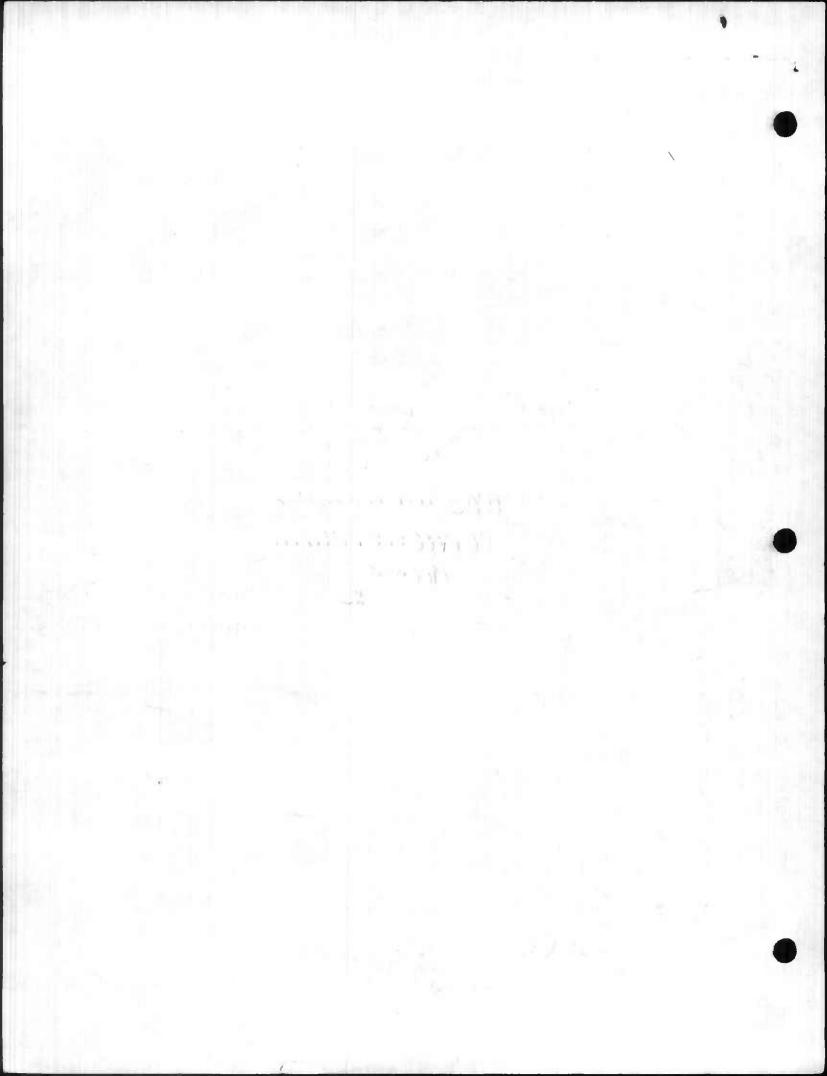


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. *Amended item#26 perPhyG781 3/18/2000 EW State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#26per doctor, 2/2/00 FCHD, KS 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** DEMPSEY 9:37 AM January 6, 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7813 Rocky Springs Road Frederick ff Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M F Months Director 053-20-3818 Sept. 26, 1928 New York 10a State 10b. County 10c. City. Town or Location than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Nes 2 No Director Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7813 Rocky Springs Road death y 21702 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: 1 □ Never Merried 2 N Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ifiled within 7 I Hygiene. other then "n Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled with Department of Health and Mental Hyglent Important: if tem 27 is marked other that any jolury or other traumatic event, the lands. 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First Middle Last) 8 Daniel P. Duhan Beatrice Fee 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Dempsey / husband 7813 Rocky Springs Rd., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 1/11/00 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. garquetre Kruh 1621 Opossumtown Pike, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel cerebral hemorrhage 2 month diseese or condition resulting in deeth) Examiner Examiner Subarachnoid humorhage physicien and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): with coundin anticoagulation Box 68760 Physician/Medical Due to (or es a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown Records, by 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? ia certificate h director, pagr 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vitai To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After thia certifica completely filled in by the funeral director; I Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 1/7/2000 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Baughman Lane Frederick Janet Ciarkousky GM 110 31. Date filed (Month, Day, Year)

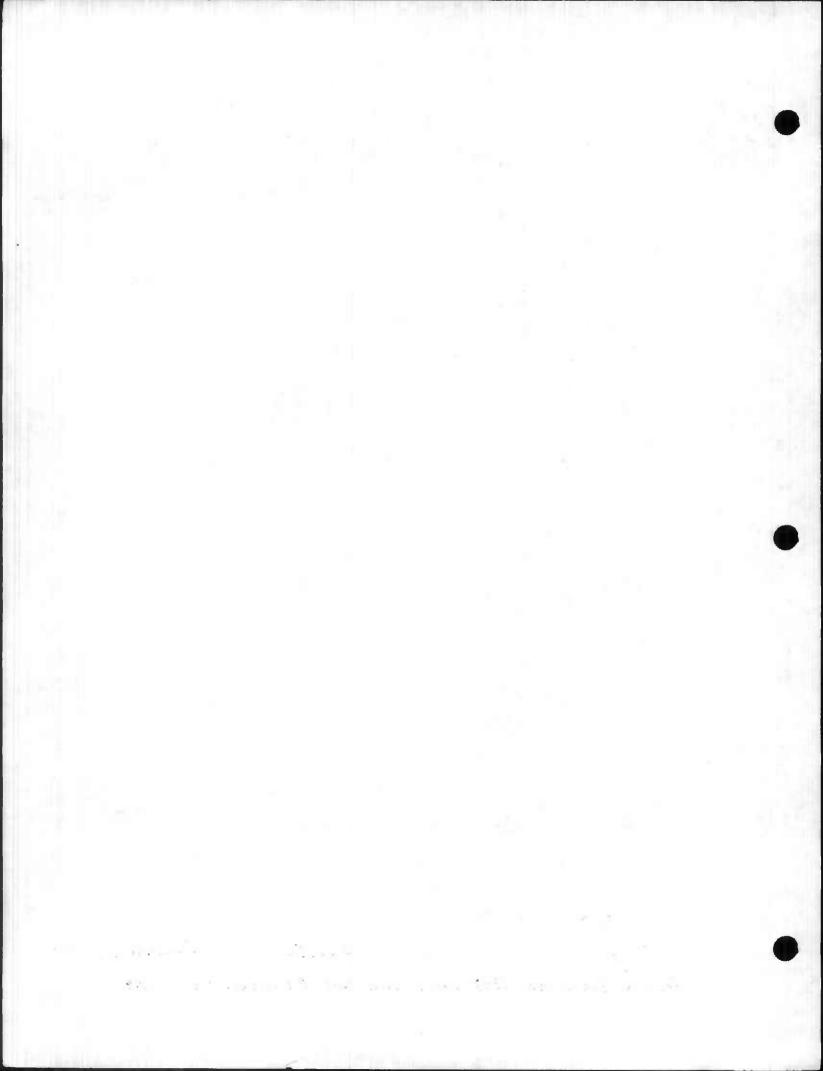
JAN 0 7 2000 32. Redistrar's Signature State Registrar



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State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 1 7

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| | s case referred to med miner? Yes 2 🛣 No | Yes 2 🖟 No ner of Death Natural 5 □ Pending Accident Suicide 6 □ Could not be | s case referred to medical miner? Yes 2 No Ner of Death Natural 5 Pending Accident Suicide 6 Could not be 28e. Place of Inju (Month, Da) | scase referred to medical miner? Yes 2 No Ner of Death Natural 5 Pending Investigation Suicide 6 Could not be determined Accident Suicide 6 Could not be determined Suicide 1 Certifying Physicien: To the best of my knowle-beck only 2 Medical Examiner: On the basis of examination | scase referred to medical miner? Yes 2 No New Yes 2 No Hospital: 1 Inpatient 2 ER/Outpate Natural 5 Pending Investigation Suicide 6 Could not be determined Suicide Homicide 1 Certifying Physician: To the best of my knowledge, deneated only and manner stated. | scase referred to medical miner? Yes 2 No Ner of Death Natural Accident Suicide Homicide 1 Certifying Physician: To the best of my knowledge, death occurre beck only ner of the determiner on the last of examination and/or investigation and manner stated. | Scase referred to medical miner? Hospital: 1 IX Inpatient 2 ER/Outpatient 3 DOA Office Injury (Month, Day Year) Suicide Homicide 1 | Scase referred to medical miner? 26. Place of Dot | Scase referred to medical miner? Yes 2 No | Scase referred to medical miner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursin | Pneumonia scase referred to medical miner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ner of Death Natural 5 Pending Investigation Suicide 6 Could not be determined Phomicide 88. Place of Injury 288. Time of Injury 4 Work? 1 Yes 2 No 288. Place of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 89. Pending Investigation Suicide 6 Could not be determined Phomicide 289. Place of Injury 4 Pear 1 Yes 2 No 281. Location (Street end Number or Rural Injury or Town, State) 281. Location (Street end Number or Rural Injury or Town, State) 282. Place of Death (Check only one) 183. DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 283. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 284. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 285. Time of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 286. Place of Death (Check only one) 286. Place of Death (Check only one) 287. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 288. Place of Death (Check only one) 289. Place of Death (Check only one) 280. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 280. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 281. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 282 Nursing Home 5 Residence 6 Other (Specify) 283. Describe how injury occurred Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 284. Describe how injury occurred 1 Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 285. Time of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 286. Place of Death (Number or Rural Injury 4 Nursing Home 5 Residence 6 Other (Specify) 286. Place of Death (Nursing Home 5 Residence 6 Other (Specify) 287. Death (Specify) |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 01,1,1,8

| | | | Certi | ficate of | Death | Re | g. No. | UH | 440 |
|-------------------------------------|--|--|-------------------------------|----------------------------------|--|-------------------------------------|------------------------------|--|-----------------------------|
| | 1. Decedent's Nama (First, Middle, L | rst) | | | | 2. Data of Death | 1 | | Tima of Death |
| ysician Medical | MILLER | JONES EVAN | S | | | JANUARY | 26 200 | 0 : | 1219 P.M |
| aminer | 4a Facility Nama (II not institution, gi | | | | 4b. City, Town, or | Location of Death | | | |
| | SOUTHERN MARYLAN | | | Williams A Van | CLINTON | T | | an of What Country? USA In Race - Amarican Indian, Black, White, etc. In Business/Industry LF EMPLOYED In Mr. State, Zip Code) TY, VA. 22193 ation - City or Town, Stata SHAW, S.C. ME H, DC. 20011 Approximate Interval Between Onset and Decider (Specify) 24b. Were autopsy find available prior to completion of cau of death? In Other (Specify) Occurred | |
| al or | 249-64-3885 | Sex. 7. Age (In yrs. 12 M 2 F 6 | | If Under 1 Yaar Nonths Days | | (Month Day | Year) 1939 S | Country | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State 10b. County | 10c. Ci | y, Town or Local | ion | | | | 10d. Ir | side City Limits |
| tor | MD P.G | · OX | ON HIL | L | | | | 1 | Yes 2□No |
| ai Director | 10e. Street and Number 1835 KNOLL D | RIVE | | 10f. Zip Code | 20745 | 10 | Og. Citizan of Wha | at Country? | |
| by Funeral | 3Ã Widowed 4 ☐ Divorced | 12. Was Decedant Evar in U Armed Forces? 1 ☐ Yes ②Ã No If Yea, Give Year or Datas: | | s Decedent of es, specify Cul | Hispanlc Origin? (Span, Mexicen, Puarl Specify: | pecify Yas or No- o Ricen, atc.) | Black | White ato | |
| sted | 15. Decedent's E (Specify only highest gi | | 16a. Deceden | t's Usual Occu | pation during most of wo | rkina | 16b. Kind of Busin | ness/Industry | / |
| Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO | NOT use retire ENTER | ed) | | SELF E | EMPLO | YED |
| To Be C | 17. Fathers Name (First, Middle, Las | | | | 18. Mother's Nav | me (First, Middle, MIE MIL | | | |
| _ | 19a. Informant's Name/Retationship | (Type, Print) ANS (DAUGHTER | | | | | | | |
| | 20e. Method of Disposition | 20b. F | Place of Dispositi | on (Neme of | | | | | |
| | 1 Denation 5 Other (Spec | JHemoval from State | oss Ro | | T.CEM.2 | /5/00 | KERSHAV | V.S.C | |
| | 21. Signature of Europaral Service Lice | | - | | ess of Facility OYSTER | | | | • |
| | 1/11 | Mul | 3.8 | | | | | 200 | 1 1 |
| by Physician/Medical Examiner | disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (c | or as a conseque | nce of): | | 6 | | | |
| clan | | | | | | 1 | | | |
| Physician/ | Part II. Other significant conditions | contributing to death but not res | ulting in the unde | erlying ceuse g | iven in Part I. | | | | 1 |
| Completed by | | | | | | 24a. Was ai | | availab | e prior to tion of cause |
| | | | | | | 1 X Ye | s 2 No | 1000 | s 2 No |
| Be | 25. Was cesa referred to medical examiner? | Hospitat: | | | ther | ath (Check only on | | | |
| 10 | 1)X) Yes 2 ☐ No 27. Manner of Death | 1 L Inpatient 2 L | ER/Outpatient 28b. Time of | JA DUA | 4 LI Nursing P | fome 5 Reside | once 6 Other | | |
| ation | 1 Netural 5 Pending 2 Accident Investigation | | Injury | 28c. tnj W | ork? ☐Yes 2☐No | | | | |
| Certification: | 3 Suicide 6 Could not determined | | ome, ferm, stree y) | , factory, office | | 28f. Location (St. City or Town | reet and Number n, State) | or Rural Ro | ute Number. |
| edical C | | hystclan: To the best of my knominer: On the basis of examine and manner stated. | | | | | | | |
| Me | 29b. Signatura and titl Col certifier | Ulix un | | O.C. | .M.E | | 9d. Date signed (| Month, Day. 27, 20 | |
| | 30. Name and address of person who | | | | n Street | | | | 21221 |
| | THEODONE MIL | | | | an Channah | I les I de menore | | | |

DHMH 16 Rsv 6/95

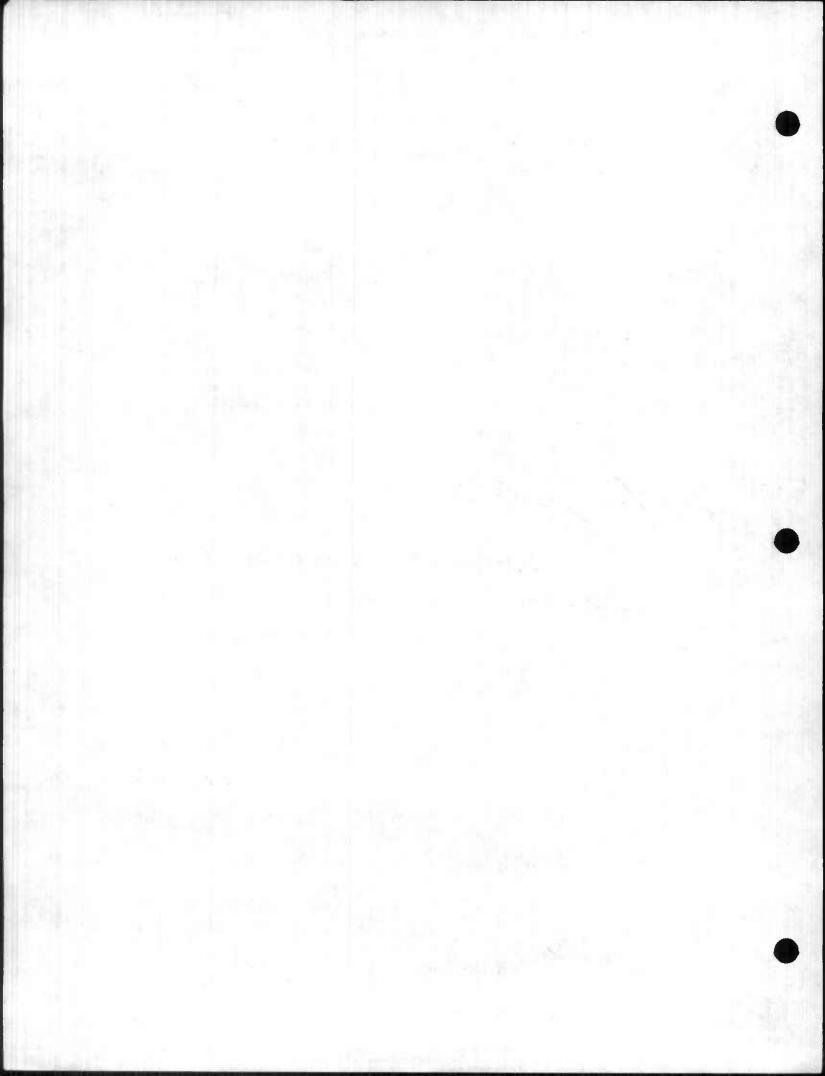
State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2000

Sparks.

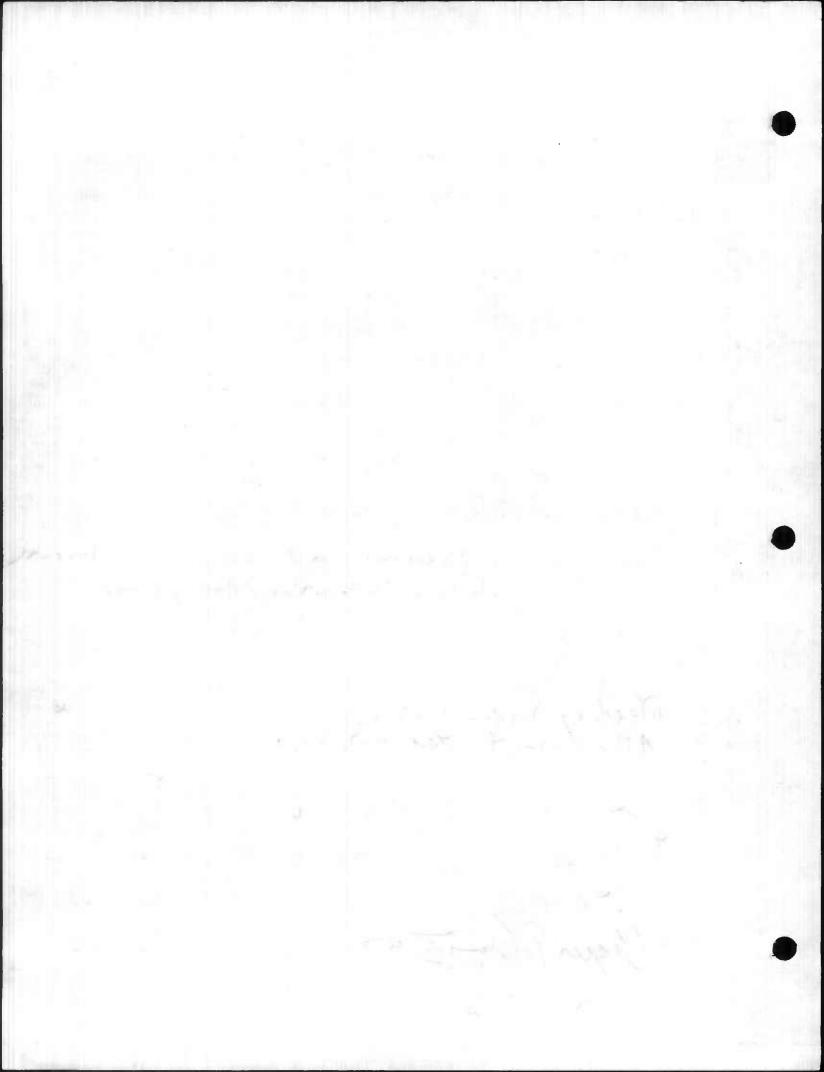


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2000 January 26, 1:50 P.M. **JAMES** HARBAUGH EBY /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick Citizens Nursing Home Frederick If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Yrs. 217-05-6317 Director 89 1910 March 4, Maryland Usuel Rasidence of Decedent the Maryland 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits rail, or harms 23a or 28a-f ahow Examiner must be notified at MXYes 2 No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Water Street 21788 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Emericans 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes ZXXNo If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes ②CXNo Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 7 th College (1-4or 5+) Repairman Shoe Store 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Nina Harbaugh Hugh Eby 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zio Code) Allen Miller, nephew 11 Elm Street Thurmont, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete XX Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Blue Ridge Cemetery 1/29/00 Thurmont, Maryland 22. Name end Address of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Futheral Service Licenses 104 East Main Street Thurmont, Maryland 21788 23a Part Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory arrest, thosis, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Causa (Final 120041 diseese or condition resulting in deeth) Examiner enm 00 Due to (or es e consequence of): Physician/Medical Examiner the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequenca of) The law requires that the death certificate be execu Box 68760. Due to (or es a consequenca of): US6 AS P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Be Completed 24b. Wera autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause 2 1 NO 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medicel examiner? 26. Placa of Death (Check only ona) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No edical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide Hospital 29e. Certifier 1 Sertifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to tha cause(e) and mannar es stated. completely (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. one) \$ 29b. Signetury nd title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 00 30. Name a person who completed cause of deeth (Item 23a) (Type, Print) 300 Street Frederick 8 2000 Signeture

Registrar **DHMH 16 Rev 6/95**

State



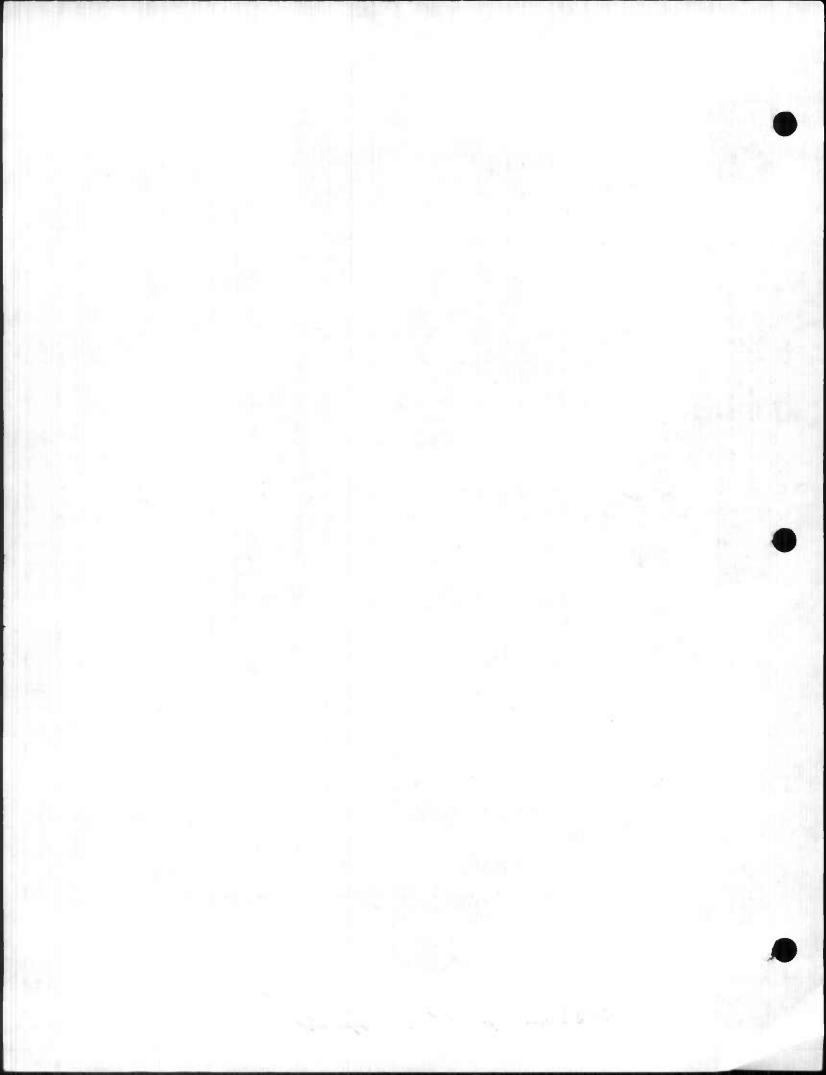
Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death Dev Month Year **Physician** FREY ETHEL 4:11 PM JANUARY 28, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) | ff Under 1 Year | If Under 24 Hrs. | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 17 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 10 M X3F 75 July 4, 1924 Director Maryland 218-12-7234 Usual Residence of Decedent 10c. City, Town or Location Randallstown with the Maryland 10b. County 10a. State 10d. Inside City Limits Show r than "natural", or Nama 23a or 28a-f show the Medical Examinar must be notified at Baltimore MD Director 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 5412 Old Court Road USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian. Id be filed within 72 hours after do ental hygiene. Ked other than "natural", or flem c event, the Hed cells. Bleck, White, etc. 1 ☐ Yas 2 XNo If Yes, Give 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 N Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event ables. Be Thomas Limish Viola Frey 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5705 Bartholow Road Sykesville, MD 21784 Ms. Betty Cook (Niece) 20a. Method ol Disposition 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State White Rock Church Cemetery 2/2/2000 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility HAIGHT FUNERAL HOME & CHAPEL (PO BOX 195) uan 6 Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart leiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) CARDIOMYOPATH . CONGESTIVE Examiner Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown SEIZURE Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed MITRAL STENOSIS page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION of Vital or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2☑ No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division 1 Netural death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29e. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated. Medical within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. \$ 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 2 IC. S. RAO.M.O. 043462 JANUARY 28, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) K. S. RAO · M.O. 5401 Old COURT ROAD NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MO

State Registrar

31. Date filed (Month, Day, Year) JAN 3 1 2000

32. Registur's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** MARIE RITA FITZGERALD TANUARY 10:15 Pm 30 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth Hours Min. May 11 Dorchester Gereral Dorchester Hospital If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 25F 177-14-7176 78 Yrs. Pennsylvania Director Usuai Residence of Decedent 10e. State 10b. County 10c. City, Town or Location r 25a-f show i notified at 10d. Inside City Limits the Marylar MD Dorchester Cambridge 1 ☐ Yes 2 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or : the Medical Examiner must be n 104 Buena Vista Ave. 21613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritei Stetus Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Z No Specify: white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is merked other than "nati any injury or other traumatic event, the Medical Elementery/Secondery (0-12) College (1-4or 5+) rate adjuster insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be William Begley Mary Flynn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James P. Fitzgerald-husband 104 Buena Vista Ave. Cambridge MD 21613 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State St. John Neuman Cemetery 2-5-2000 Chalfont, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 meto 23a. Part1. Enter the disease, or complications that cause on leath. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset end Death **Physician** /Medical immediate Cause (Finel disease or condition resulting in death) · Anoxic Brain Injury week Examiner Due to (or as a consequence of): Physician/Medical Examiner Renal Failure physician end the burial-transit lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last · Myocardial Infarction Division of Vital Records, P.O. Box 68760, neek Due to (or es e consequenca of): 80 Hyper calcemia Iweek 980 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Chronic Obstructive Pulmonary Disease page 2 2 4No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Placa of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 12 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 PNaturai 5 Pending investigation e Hospital or Attending n 24 hours after death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date aigned (Month, Dey, Year) 30. Name and address of person who completed cause of death (item 23e) (Type, Print) MARK E. VELARDE, MD

Cambridge

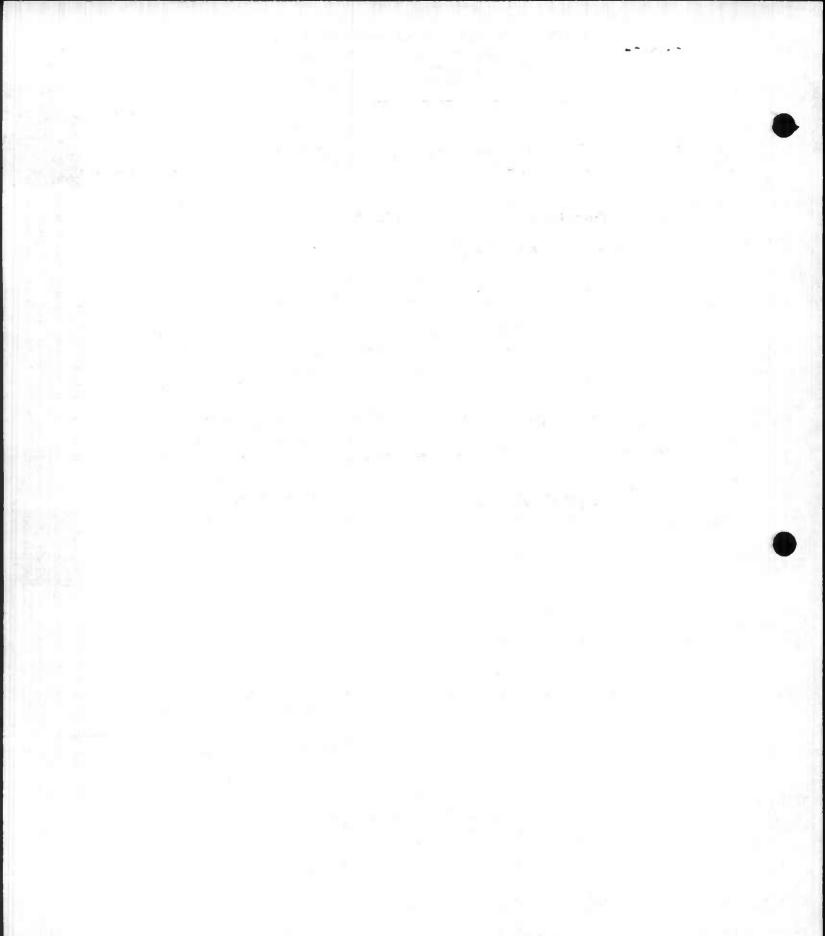
32. Registrar's Signeture

Suite

503 Byrw 5T =

MARY ZAND

State Registrar



Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CLOYDE FISHER 2000 2048 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL If Under 24 Hrs. 7. Age (In yrs. last birthday). 79 Yrs. if Under 1 Year 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9-5-20 5. Social Security Number **Funeral** Days 1 ☐ M 2 🔀 F MD. **Director** 213-18-7852 Uaual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or flams 23s or 28s-f show other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director MD. OCEAN CITY WORCESTER 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code 119 OLD LANDING RD. 21842 14. Race - American Indian, Black, White, atc. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fler any Injury or other traumatic avant, the Medical Empired 1 Yea 20 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yea 2 No Specify: Specify: WHITE þ 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 MANAGER CREDIT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DEFOREST TERRY 2 MARY TERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD FISHER 119 OLD LANDING RD. OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cremation 3 ☐ Ramoval from Stata SALISBURY CREMATORY 4 ☐ Donation 5 ☐ Qthar (Specify) SALISBURY, MD 21. Signature of Funaral Survice Licens 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final . ASCVD MANY YRS disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 Tyes 2 No 25. Was casa referred to medical exeminer? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No 2 Accidant investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury · At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

The lew requires that the death certificata be axecuted Box 68760, Division of Vital Records, P.O. or Attanding Physician:

death

Baltimore, Maryland 21215-0020

certificate this Affer death. n 24 hours after death to Funeral Director: / pletely filled in by the Hospital

State

edical

29a. Certifier

(Check only

DOROTHY 31. Data filed (Month, Day, Year)

29b. Signature and title of certifian

30. Name and address experson who complated sayse of death (Item 23a) (Type, Print) OLZINUZTH 32. Registrar's Signature

And was

203 SNOW ST. SNOW HILL, M marke

1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

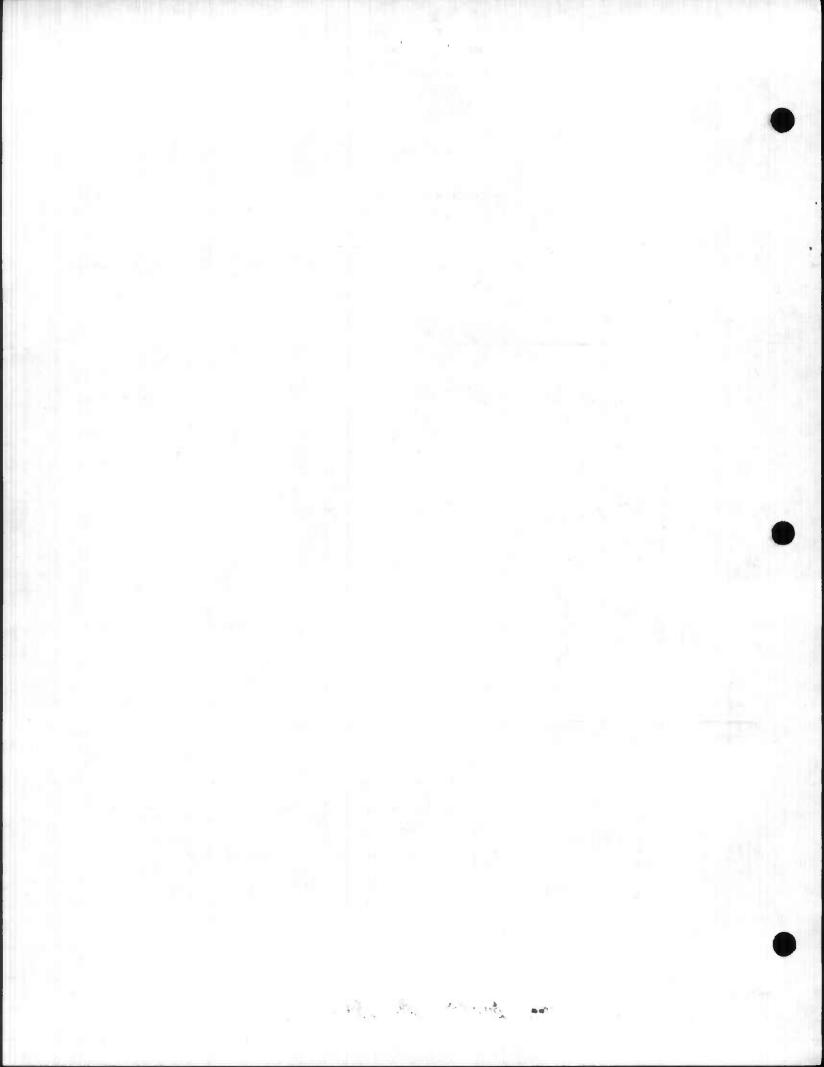
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

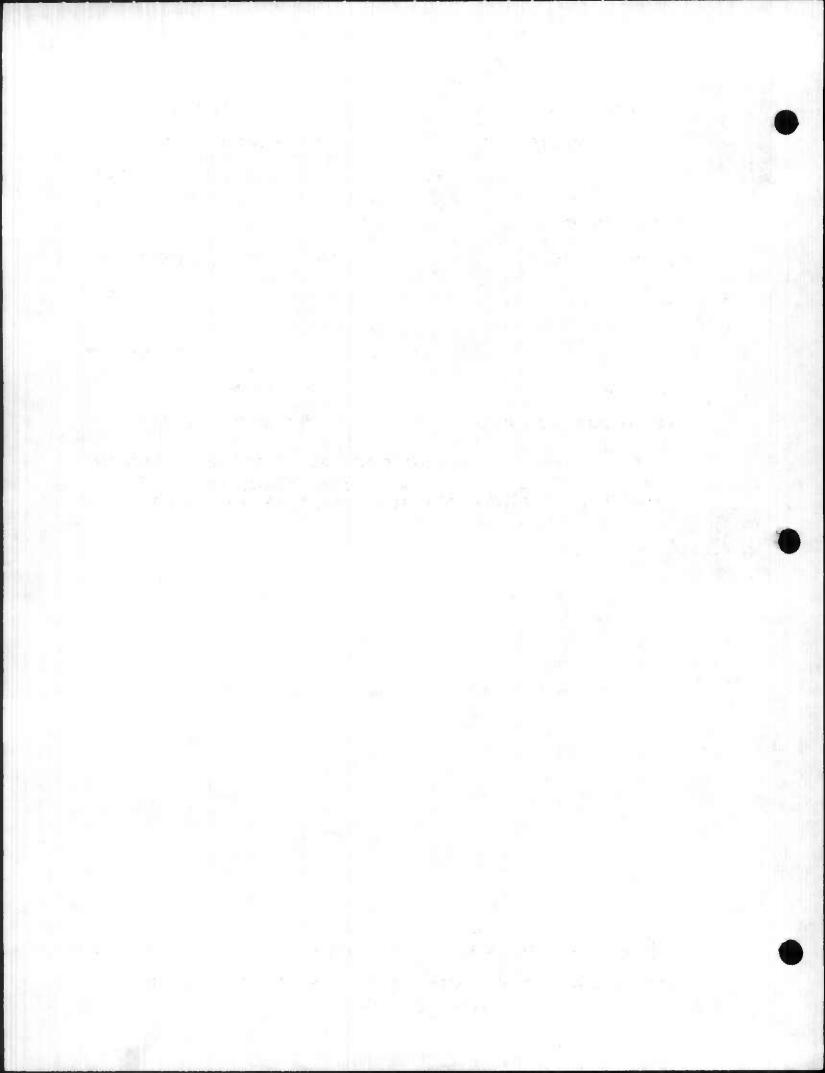
State of Maryland / Department of Health and Mental Hygiene 00 0 1; 1; 5 3.

| | | | | | Cer | tificate o | f Death | | Reg. No. | | | | | |
|--|----------------|---|--|--|---|-------------------------------------|---|---|--|---|--|--|--|--|
| | Ţ | 1. Decedent's Nama (First, Midd | le, Last) | | | | | 2. Data of De Month | eath Day | Year | 3. Time of Deeth | | | |
| Physi /Med | | JOANNE LEE | FULMER | | | | | JANUAF | | | 8:25 AM | | | |
| Exam | | 4a Facility Nama (If not institution | n, give street and numbe | r) | - | 14-11 | 4b. City, Town, o | r Location of Deat | | | | | | |
| | | 8289 GANNON C | IRCLE | | | | EASTON | | TALBO' | Γ | | | | |
| Funera | ıl | 5. Social Security Number | | Age (In yrs. lasi | birthday) | If Under 1 Ye Months Day | ar If Under 24 H | | th Iv Year) | 9. Birtho | place (State or Foreign | | | |
| Directo | r | 172-36-0810 | 1□M 201F | 54 | Yrs. | Moral ou | 110010 | MARCH 1 | 3,1945 | | NSYLVANIA | | | |
| g . | | Usual Residence of Decedent 10a. State 10b. Count | | 10c. City, T | ava as I as | ation | | | I and the | | | | | |
| aryta ahoy dat | * | MD TAL | | EAS' | | allon | | | | 1 | 10d. Inside City Limits 1 Yas 2 No | | | |
| er death with the Maryland theres 23e or 28e-f show ther must be notified at 'urneral Director | | | LAD | 1011 | | | | | | | | | | |
| 6 9 8 | 눔 | 10e. Street and Number | | | | 10f. Zip Cod | | 1.0 | 10g. Citizen of V | | ntry? | | | |
| # 23g | a a | 8289 GANNON | | | 1 | | 1601 | | U.S.A | | | | | |
| Pr de | Funeral | 11. Marital Status | 12. Was Deceder Armed Forces | 5? | Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert | | | (Specify Yes or No erto Rican, etc.) | - 14. Hac Bled | e - American Indian, ck, White, etc. | | | | |
| | by F | 1 ☐ Never Merried 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce | H Ves Give | | 1 | □Yes 2K) | lo Specify: | | Specify | CINITA | 373 | | | |
| A Por | | | rear or Dates | | So Doord | ent's Usual Oc | wasting | 9-14-14 | 16b. Kind of Bu | WHIT | | | | |
| 27 20 | Completed | | est grade completed) | ' | (Give l | and of work do NOT use net | ne during most of wired) | vorking | 160. Kind of Bu | J3111 0 33/111 | dustry | | | |
| within the Man | E | Elementary/Secondary (0-12) | College (1-4o | r 5+) | | CLERK | | | DEMATE | TAIL SALES | | | | |
| D HAND | | 17. Father's Neme (First, Middle) | | | | | | ame (First, Middle | | | ES | | | |
| Id be dental rice ev | o Be | SANDY FORLIZ | 7T | | | | JOYCE | E HARBO | T D | , | | | | |
| d Me Mark | ř | 19a. Informent'a Neme/Reletion | | | 19h Mailin | n Arldrass (Str | eet and Number or | | | State 7in | Code) | | | |
| 등 등 등 등 등 | | CHRISTOPHER M. | | | | | CIRCLE, H | | | , 0000) | | | | |
| vermit. Pages 1 and Department of Health Important: if Item 27 Iny Injury or other it | | 20a. Method of Disposition | 5 5011112227 50 | 20h Plac | n of Dispos | ition (Name of | | Date | 20c. Location - | City or Tr | own, State | | | |
| | | 1 Burial 2 Cremation | | e CHES | etery, crem APEAK | E CREMA | TION | | CHESTE | R, MI |) | | | |
| | | 4 Donation 15 Other (S | | CEN | CER, | L.L.C. | | 1/23/00 | | | | | | |
| Dept de la la la la la la la la la la la la la | | KW 5 | TA 18/ | reso | FID | NERAL H | ones of Facility FI | ELLOWS, H SOUTH HA | ELFENBE: | IN, & | NEWNAM | | | |
| | | //am | V/mm H | - TJP | E | ASTON, | MARYLAND | 21601 | | TREE | | | | |
| | | 23a Party Enter the disease, or heert leilure. Lis | only one cause on each | ed the death. I line. | Do not ente | r the mode of o | lying, such es card | iac or respiratory a | rrest, | 1 | Approximate Intervel Between Onset and Deeth | | | |
| Physician | | Immediate Cause (Finel disease or condition Endowettical Carcurages | | | | | | | | | | | | |
| /Medical Examiner | | disease or condition resulting in deeth) | end | owen | ef (| earcu | emes | | | | 5 MONTHS | | | |
| | 1 | Due to (or as a consequence of): | | | | | | | | | | | | |
| be as | Examiner | | b | | | | | | | | | | | |
| Certificate be executed nding physician and use as the burial-transit | xan | Sequentially list conditions, if any, leeding to immediate | | Due to (or as | a consequ | uence of): | | | | | | | | |
| ficate be ex physician is the buria | | | | | | | | | | | | | | |
| Phys the | edicai | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | |
| Se as | | | L a | | | | | | | | | | | |
| O the state | Physician/M | | | | | | | | | | | | | |
| d by the | YS | Pert II. Other significant conditi | ons contributing to death | but not resultin | g in the un | derlying cause | given in Part I. | 23b. Did | 23b. Did tobacco use contribute to the cau | | | | | |
| that the ed by th detach | 된 | | | | | | | 10 | Yes 2 No | 3 Pro | bably 4 Unknow | | | |
| he law requires to the law requires to the law some signer to the law been signer to the law law law law law law law law law law | d by | | | | | | | 24n Was | an autopsy | 24h W | ere autopsy lindings | | | |
| P P P P P P P P P P P P P P P P P P P | ete | | | | | | | | omed? | av | reilable prior to empletion of cause | | | |
| The law ate has b page 2 a | Completed | | | | | | | | | of | deeth? | | | |
| - F # Z | | | | | | | | 10 | Yes 2 No | 1[| Yes 2 No | | | |
| Physician: The law rthis certificate has | B | 25. Wes case referred to medical examiner? | | | | | | eath (Check only | one) | | | | | |
| Physic this c | 2 | 1 Yes 2 No | Hospitel: 1 Inpar | - | - | 3LI DOA | | Home 5 12 Resi | | | fy) | | | |
| The The The The The The The The The The | on: | 27. Menner of Death 1 ☑ Netural 5 ☐ Pendi | 28a. Data of In (Month, D | | b. Time of Injury | 28c. lr | | 28d. Describe | how injury occur | red | | | | |
| eath. | cat | 2 Accident invest | getion not be | | | | ☐ Yes 2 ☐ No | | | | | | | |
| or Attending after death. Director: After din by the fune | Certification: | 4 Homicide | nined 288. Place of II | njury - At home etc. <i>(Specify)</i> | , farm, stre | et, fectory, offic | >0 | | Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| led in a led | ပီ | | | | | | | | | | | | | |
| To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | edicai | (Check only 2 Medical | ng Physician: To the bes Examiner: On the basis | of examination | dge, death and/or invi | occurred at the estigation, in m | time, date and pla y opinion, death oc | ce, and due to the curred at the time, | date and place, | inner as s and due t | stated. o the cause(s) | | | |
| the the the the | Med | one) | and manner s | | | | | | | | | | | |
| O T TO S | | 29b. Signature end titla of certifie | RAMA | | | 0.00 | ense number | | 29d. Date signe | 3/01 | | | | |
| | | P DIVER (|) ruru | | | 1 95 | 9887 | • | 1/2 | 2/01 | 0 | | | |
| | | 30. Name and address of person | | | | - | | | | | | | | |
| | | DAVID H. SMITH | | | | IVE, SU | ITE 5, EA | STON, MD | 21601 | | | | | |
| | tate | 31. Date filed (Month, Day, Year, | | Irar's Signature | 19 | Lin | rely | | | | | | | |
| Regis | trar | JAN 2 | 4 2000 | Part of the same o | 1. | Popla | | | | | | | | |

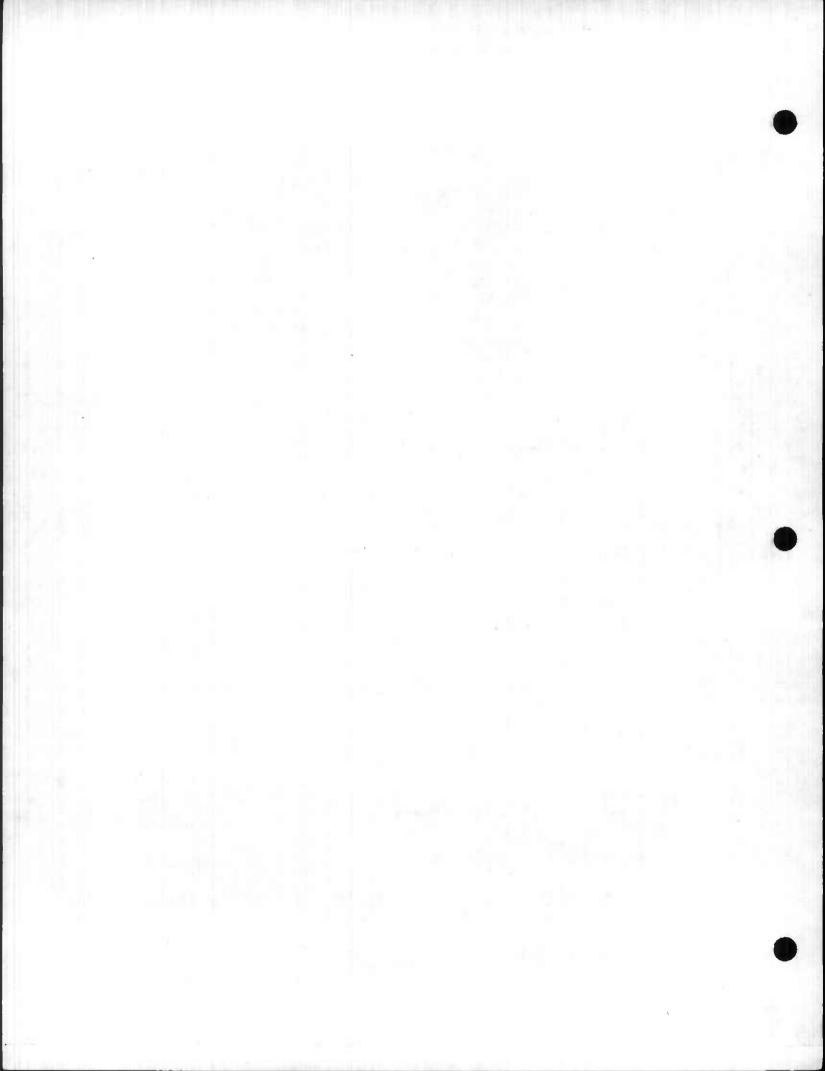
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State of Maryland / Department of Health and Mental Hygiene 1 1 1 5 1

| | | Decedent's Neme (First, Middle, | Last) | | Ce | rtificate o | Dealii | 2. Dete of De | Reg. No. | | 3. Time of Deeth | |
|--|------------------|---|--|---|------------------------------------|--|--|--|--|---|---|--|
| Physici /Medi | | VINCENZO FA | | | | | | Month JANUAR | Day | 7:10PM | | |
| Examir | | 4a. Facility Name (If not institution, | | m <i>ber)</i> | | | 4b. City, Town, or | | | - | , , , , , | |
| | | RANDOLPH HILLS | NURSING 1 | HOME | | | SILVER S | SPRING | MON | r GOMER | Y | |
| Funeral Director | | 578-52-1664 | 6. Sex 1∭2 M 2□ F | 7. Age (In yrs | s. lest birthdey) 88 Yrs. | If Under 1 Ye Months Dey | | (Month, De | B. Date of Birth (Month, Dey, Year) UNE 8, 1911 | | ace (Stete or Foreigr Y) Y | |
| A == | | Usuel Residence of Decadent 10a. Stete 10b. County | | 10c. C | ity, Town or Lo | ocation | | | | 10 | d. Inside City Limits | |
| a or 28a-f show be notified at | ō | MARYLAND HOWARD | | | | DAYTON | | | | 10 | 1 ☐ Yes 2 ☑ No | |
| 128a | Director | MARYLAND HOWARD 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Countr | v? | |
| 23a o | | 5221 KALMIA DRIV | ਸ | | | | 21036 | | UNITED : | | | |
| or items | by Funeral | 11. Maritel Status 1 Never Married 2 Marrie XX Widowed 4 Divorced | 12. Wes Dec Armed Fo | 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give | | | | | 14. Rad Bie | 14. Race - American Indian, Bieck, White, etc. Specify: WHITE | | |
| natural', disal Ex | ted | 15. Decedent's | Education | | 16a. Deced | dent's Usual Occ | upation | | 16b. Kind of B | usiness/Indu | ustry | |
| C 2 | Completed | (Specify only highest Elementary/Secondery (0-12) | grade completed) College (| I-4or 5+) | (Give | (Give kind of work done during most of life. DO NOT use retired) | | rking | | | (i) Ib | |
| | Con | 4 | | | TIL | E SETTER | 2 | | CONSTRUCTION | | | |
| 0 5 | Be | 17. Father's Name (First, Middle, La | ast) | | | | 18. Mother'a Na | me (First, Middle | , Meiden Sumen | ne) | | |
| marked matic ev | To | ORAZIO FAMA | | | | | MARIA RIGANO | | | | | |
| raum traum | | 19a. Informant's Name/Relationshi | | | | | (Street end Number or Rurel Route Number, City or Town, Stete, Zip Co. | | | | | |
| s 1 end 2 should Health end Mer tem 27 is marke other traumatic | | MARIA MARCHEGIA 20a. Method of Disposition | NI/DAUGH | | | KALMIA sition (Neme of | IIA DRIVE DAYTON, MD 21036 Date 20c. Location - City or Town, S | | | | | |
| or o | | 1 X Burial 2 ☐ Cremation 3 | | State | cemetery, cren | netory or other p | 1 | | | | | |
| Department of Heal Important: If item 2 any Injury or other once. | | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li | | WAS | | N NATION | | 1/29/00 | SUITLA | ND, MD |) | |
| any Ir | | 21. Signeture of Purietal Service Li | Cerisee | 14 | HI | NES-RINA | ALDI FUNER | RAL HOME | , INC. | | | |
| | | 23e. Part1. Enter the disease, or c shock, or heart failure. List or | · Xi/ | My C | | | HAMPSHIRI | | | - | MD 20904 Approximate | |
| ysician ledical aminer | ier | Immediate Ceuse (Final disease or condition resulting in death) | a. ALZ | | S DEME | - | | | | | PARS | |
| g physician and es the buriel-trensit | Medical Examiner | | | | | | | | | | | |
| | an/Med | vocality East | d | | | | | | | | | |
| ne ett | sick | Part II. Other algnificant conditions | contributing to de | suiting in the ur | nderlying cause | given in Part I. | 23b. Did | . Did tobacco use contribute to the cause of d | | | | |
| igned by the ettendir be deteched for use | by Physician/ | SENILE INANI | TION | | | | | 10 | Yes 2 No | 3 Probe | ably 4 Unknown | |
| s been s 2 should | Completed | | | | | | | 24a. Was perfo | an autopsy rmed? | com | e autopsy findings lable prior to pletion of cause eath? | |
| p ate | | | | | | | | 10 | Yes ZXNo | 10 | Yes 2□ No | |
| certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hoenital | | | | | ath (Check only o | one) | | | |
| this of | 2 | 1 ☐ Yes 2∑No 27. Manner of Death | | | ER/Outpatien | T 3LI DUA | **** | lome 5 Resident | | 1-1-17 | | |
| ctor: After this certific y the funeral director, | Certification: | 1XX stural 5 ☐ Pending investigat 3 ☐ Suicide 6 ☐ Could no | tion | of Injury | Injury | M 28c. In W | Yes 2□No | Yes 2 □ No | | | Paulo Mumbar | |
| To the Funeral Director: completely filled in by the | | 4 Homicide determine | buildle | ng, etc. (Specia | fy) | ot, lactory, onlo | | City or To | cation (Street end Number or Rurel Route Number, ty or Town, State) | | | |
| To the Funeral Direct completely filled in by | edicai | 29a. Certifier (Check only one) Check only one) | Physician: To the aminer: On the be and mann | sis of examine | owledge, death etion and/or inv | occurred at the estigation, in my | time, date end place opinion, death occu | , and due to the rred et the time, | cause(s) end me dete end pleca, | enner es stat end due to ti | ted. he cause(s) | |
| Tot | Σ | 29b. Signature end title of certifier | - | 10 | | 29c. Lice | nse number | | 29d. Date signe | d (Month, De | ey, Year) | |
| 4 | | 30. Name end eddress of person wh | no completed walk | e of deeth (Iter | n 23e) (Tvpe: i | D08 | 944 | | JANUARY | 27, 2 | 2000 | |
| | | MARTIN C. SHARGE | | | | | ENSINGTON | , MD 208 | 95-2110 | | | |
| Stat | e | 31. Date tiled (Month, Dey, Year) | | egistrar's Signa | | book | | | | | | |



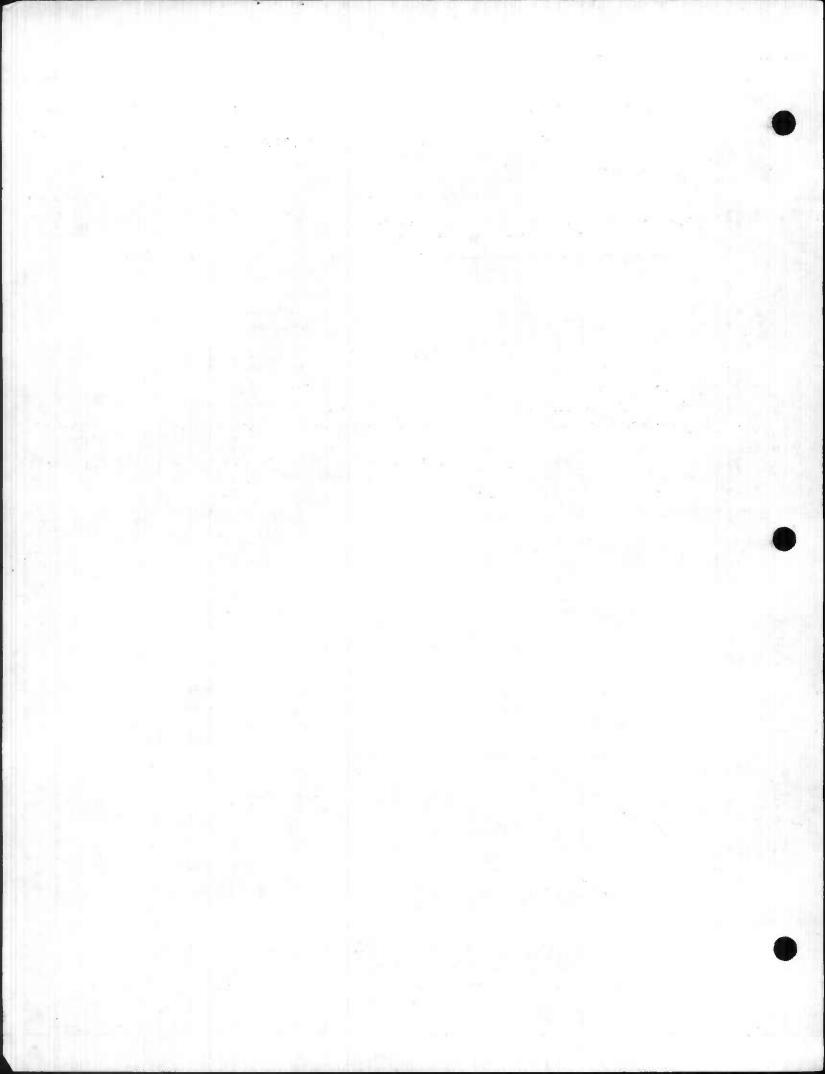
| | | | | , | Certifica | ate of | Death | | Re | g. No. |) (| 4499 | | |
|--|---|--|--|---|--|------------------------|--------------------------|---------------------------|---|--|-----------------------|---|--|--|
| | Physician | 1. Decedent'a Neme (First, Middle, La | st) | | | 2 | . Dete of Deeth Month | | Yeer | 3. Time of Death | | | | |
| | /Medical | | LIPOV | | | | | | ANUARY | T | | 7:58AM | | |
| | Examiner | 4a Facility Name (If not institution, giv | |) | | | 4b. City, Tow | | | 4c. County of | | | | |
| | Funeral | HOLY CROSS HOSPI 5. Social Security Number 6.5 | | ge (In yrs. last birt | hday) If Unc | der 1 Year | | | | MONTG | | ice (State or Foreign | | |
| в | Director | 577 44 3581 | OM 20 F 82 | | rs. Month | a Days | Hours | Min. OC | Date of Birth (Month, Dey, T. 24, | 1917 | UKR | AINE | | |
| n 72 ho n 72 ho | Usuel Residence of Decedent 10a. State 10b. County MD MONTG | OMERY | 10c. City, Town | or Location ER SPRI | .NG | | | | | 100 | d. Inaide City Limits | | | |
| | 10e. Street and Number 12525 MONTCLAIR | DRIVE | | 101. 2 | Zip Code | 20904 | | 10 | g. Citizen of W | hal Countr | у? | | | |
| | F. F. | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces | 2. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent If Yes, specify 1 | | | | in? (Specit Puerto Ric | ly Yes or No- can, etc.) | 14. Race - American Indian, Bleck, White, etc. Specify: WHITE | | | | |
| | ygiene. Ner then "netura It, tra Medical Completed | 15. Decedent'a E (Specify only highest on Elementary/Secondary (0-12) | | | Decedent'a Us (Give kind of v life. DO NOT LIBRAR | work done use retin | during most o | of working | | 6b. Kind of Bus | | CONGRESS | | |
| | d other event, Be C | 17. Father's Name (First, Middle, Last |) | | | | 18. Mother | a Neme (/ | First, Middle, M | faiden Sumame | 9) | | | |
| re, N s 1 and l Haaith tem 27 other ti | Mente To E | THOMAS FILIPOV | | | | | ZINA | IDA N | OVIKOV | | | | | |
| | aith and 27 is m r traum | 19a. Informant's Name/Relationship (ANDREE N. FILIPOV | | Rural Route Number, City or Town, State, Zip Code) SILVER SPRING, MD 20904 | | | | | | | | | | |
| | ant: If hem ary or oth | 20a. Method of Disposition 1 Burial 2 Cremation 3XXRemovel from State ST. AND REW UKRAINIAN ORTHODOX CHURCH CEMETERY 2-3-2000 Co. Location - City or Town, State SOUTH BOUND BROOK, I Dete South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Bound Brook, I detection - City or Town, State South Brook, I detection - City or | | | | | | | | | | | | |
| Bait | Department of Important: If Important: If I any Injury or DOCE. | 21. Signature of Foreign Service Lices | 1500 | (Lef | - | | | | RINALD NG, MD | | NEW | HAMPSHIRE | | |
| | | 23a. Part1. Enter the disease, or com shock, or heart feilure. List only | plications that cause | d the death. Do n | ot enter the m | ode of dy | ing, auch es c | ardiac or r | espiretory arre | st, | 1 / | Approximate Interval Between | | |
| | hysician /Medical | Immediate Cause (Finet disease or condition | | | | Onset and Death | | | | | | | | |
| E | xaminer | resulting in death) | a | Due to (or as a c | consequence o | d): | | | | | 1 | | | |
| 3 | nsk nln | | bCHRONIC | OBSTRUC | | | NARY D | ISEAS | E | | i | | | |
| 0, | physician and s the burial-transit edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | CONGEST | Due to (or as a c | - I ALLEY | | | | | | 1 | | | |
| (68760, | 0 4 | that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | | | |
| Box | for use | | d | | | | | | | | | | | |
| . 0 | 9 7 7 | Part II. Other significant conditions of | ontributing to death b | ributing to death but not resulting in the underlying cause given in Part f. | | | | | | 23b. Did tobacco use contribute to the cause of death? | | | | |
| م م | gned by be detected | | | | | | | _ | 1 🗆 Ya | 10 2 No | 3 Probe | ably 4 Unknown | | |
| Records, | 2 2 | | | | | | 4 | _ | 24a. Was ar perform | | avai | re autopsy findings lable prior to apletion of cause eath? | | |
| = F | Page Com | | | | | | | | 1□ Ye | s 2 No | 10 | Yes 2□ No | | |
| Vitai | is certificata director, pag To Be Co | 25. Wes case referred to medicat examiner? | Hospital:/ | | | | | of Deeth (| Check only on | 9) | | | | |
| of Vita | 돌을 L | 1 Yes 2 No | 1 L/Inpati | | | DON | | - | | nce 6 Other | | | | |
| Vision | After fune | 1 Netural 5 Pending 2 Accident investigation | (Month, De | 28a. Date of Injury 28b. Time of 28c. Injury at 28c. Injury at Work? 1 Yes 2 No | | | | | | w majory cocom | 00 | | | |
| | | 3 Suicide 6 Could not b 4 Homicide determined | 286. Place of in | 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | f. Location (Sti City or Town | reet and Number, State) | er or Rural | Route Number, | | |
| Hospit | within 24 hours after To the Funeral Dir completaly filled in Medical Cert | | ysician: To the best niner: On the basis o and manner st | d examination and | | | | | | | | | | |
| 5 | Nethin | 29b. Signature and title of certifier | | | 2 | 29c. Licen | se number | | 25 | d. Date signed | (Month, D | ley, Year) | | |
| | iD | 1. Bols | D47978 1/30/00 | | | | | | | | | | | |
| | 10 | 30. Name and address of person who | completed cause of o | death (Item 23a) (| Type, Print) | | | | | | | | | |
| | | LILA BAHADORI | | | A AVE. | SILV | ER SPR | ING, | MD 209 | 02 | | | | |
| | State | 31. Date filed (Month, Day, Year) | 10 32 Bioglati | mr's Signature | 1 / | a V | , | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04456 amend item 10e, 19b, 19a per fh G781 3/1/00 vg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lawrence F. Flamini 3:50pm 31, 2000 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. Da MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10M 20F 69 Director 186-24-0549 27, 1930 Pennsylvania Usual Residence of Deceden the Meryland 10s. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Germantown 10e. Street and Number 18701 Sparkling Water Drive Apt. K 10f. Zip Code 10g. Citizen of What Country? 18701 Sparklin Water Drive Apt. 20874 United States death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status Bleck, White, etc. 72 hours effer 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2☑ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Drug Enforcement Clerk 4 treumetic event, Baitimore, Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cesare Flamini Teresa A. Simone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Spark ling 19a. Informant's Name/Relationship (Type, Print) Mary Jean S. Flamini, Wife Department of Heelth er Important: If hem 27 le any injury or other treu ande. 20874 Maryjean Streeter 18701 Sparklin Water Drive Apt. K, Germantown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Peter & Paul Cemetery 2/5/00 Broomall, Pennsylvania permit. 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 21. Signature of Funeral Service Licenses oberte Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and the burlei-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Box 68760. estive Oha Physician/Medical ited events in death) Last Due to (or as a consequence of): resulting in de 80 P.O. eigned by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 3-Wiknown Records. þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 1 The state of 2 0 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Maryller of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 E3Natural n 24 hours efter deeth.

Ne Funeral Director: A pletely filled in by the fo deeth. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3∏ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31, 2000 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 Dr. Thai McGrievy 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 03 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 04457 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Frank M. Fox January 30, 2000 6:30 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House/ Montgomery Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Months 1⊠M 2□F 84 Yrs August 20, 1915 Pennsylvania 176-05-8831 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9928 Silverbrook Drive 20850 United States 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Nevar Married 28 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Airline Captain Airlines 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) George J. Fox Mary McCann 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Evelyn K. Fox/ Wife 9928 Silverbrook Dr., Rockville, MD 20850 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, State cematary, cremetory or other place) 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata Jan. 31, 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 21. Signature of Funaral Service 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Rockville, Maryland 20850-2805 Avenue, M00689 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, milura. List only one ceuse on each line. Approximate Intarval Between Onset and Death Immediata Ceuse (Final diseesa or condition resulting in death) a Cerebrovascular Accident 16 days Due to (or as a consequence of) Due to (or as e consequence of):

Physician /Medical Examiner

physician and the burial-transit certificate be executed

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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

To the Fune completely f

12

page 2

funerel

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

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the Medical Examiner must be notified at

'natural', or flerns 23s or 28s-f

Director

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hours after

Hygiene. Hygiene. Other then "n

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: if fleen 27 is marked offile any injury or other the

altimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be L_o Certification:

Renal Failure 25. Was casa rafarred to medical examinar? 1 Yas 2 No

27. Mannar of Death

1 Natural

2 ☐ Accident

4 Homicida

(Check only onel

3 Suicide

29a. Certifier

Sequentially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Prostate Carcinoma

Due to (or as a consequence of):

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

28b. Time of

26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

Other: 4 Nursing Homa 5 Residence 6 SOthar (Specify) Hospice 28c. Injury at Work?

1 Yes 2 No 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. License number

29b. Signature and titla of confiler

5 Pending invastigation

6 Could not be datarmined

D37620

January 30, 2000

23b. Did tobacco usa contribute to the cause of death?

1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed causa of death (Item 234) (Type, Print)

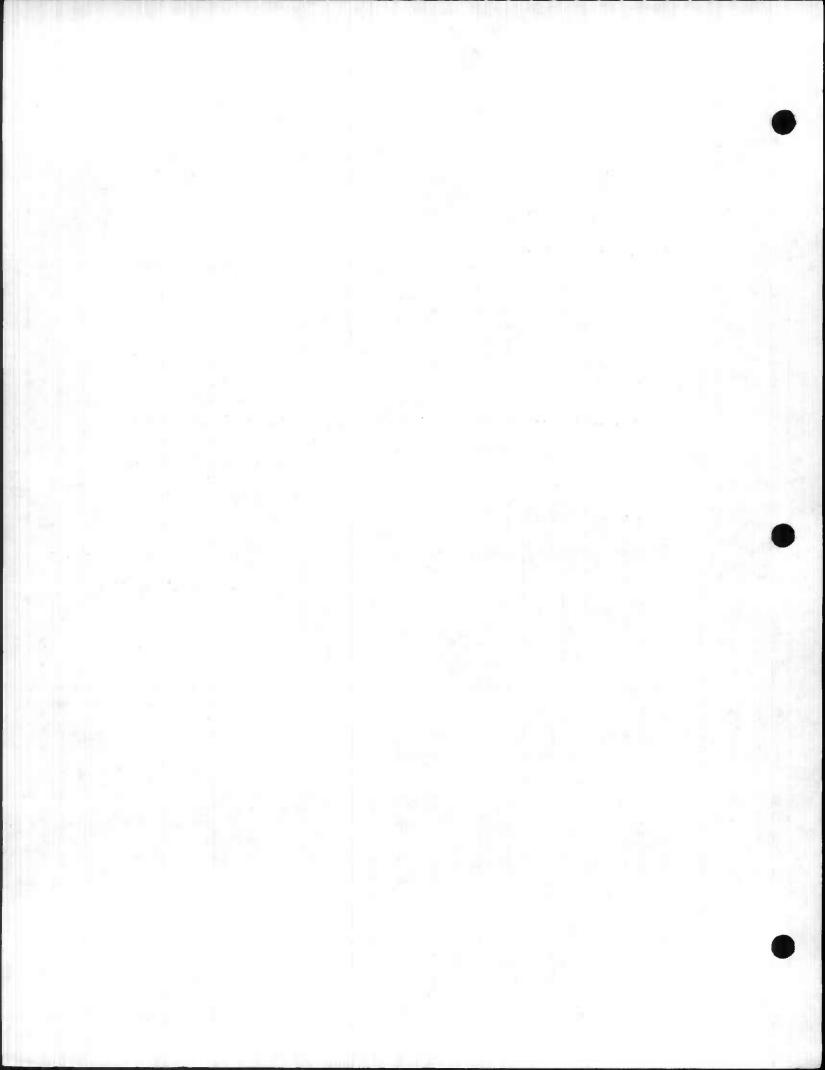
Mark S. Godec, M.D. 6001 Muncaster Mill Rd., Rockville, MD 20855

State Registra

31. Date filed (Month, Day, Year) FEB 1 2000 32. Registrar's Signatura

28a. Deta of Injury (Month, Dey Year)

souls



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06458 Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year ESTELLE FRIEDMAN JANUARY 27, 2000 12:00 AM 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Days Hours Months 1 M 2 F 82Yrs 087,10,9265 Usual Residence of Dec NEW YORK 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits MONTGOMERY BETHESDA 1 ☐ Yas XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 WESTLAKE TERRACE 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT RETAIL 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) LOUIS BLOCK BERTHA DICKER 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEPHEN FRIEDMAN/SON 10110 DAPHNEY HOUSE WAY, ROCKVILLE, MD 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata etary, crematory or other place) N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 1.30.2000 OLNEY, MARYLAND 21. Signature of Funeral & rvina Licenses 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immediata Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE 10 DAYS Due to (or as a consequence of): CIRRHOSIS OF LIVER Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona)

Physician /Medical Examiner physician and s the burial-transit The law requires that the death certificate be assouted Box 68760.

Physician

/Medical

Examiner

MD

Directo

Funeral

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r than "natural", or items 23s or 23s-f the Medical Examiner must be notifie

with the Maryland

death

hours after

filed within 72 Hygiene.

permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy importants if New 27 is marked other any Injury or other the

21215-0020

altimore, Maryland

Examiner signed by the a d be detached f pege 2 director, this funeral After Attending I after death.
I Director: After In by the fu To the Hospital or A within 24 hours after To the Funerel Direc completely filled in b

P.O.

Records.

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS þ Completed 80 25. Was case referred to medicat examiner? Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 TYas 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. edical

10

(Check only one)

29b. Signature And title of certifier

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

A. MENDHIRATTA 2401 RESEARCH BLVD SUITE 340, ROCKVILLE, MD 31. Data filed (Month, Day, Year)

State Registrar

FEB 02 2000

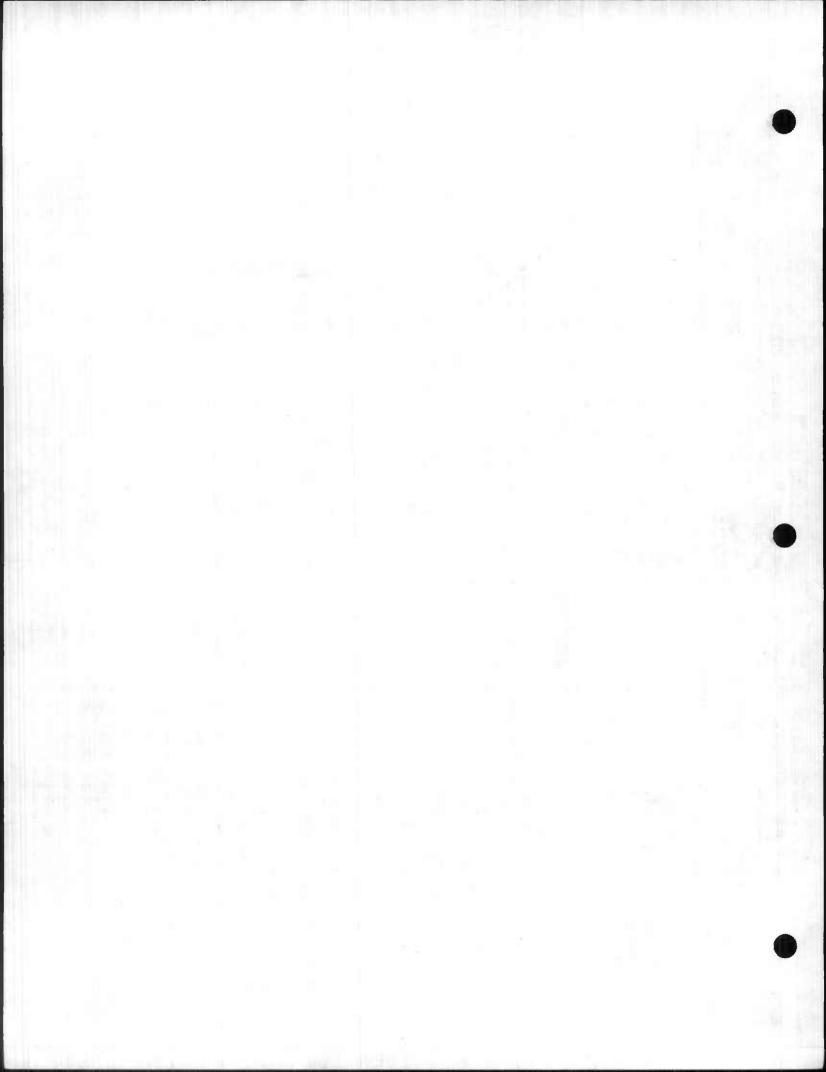


2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D38262

29d. Date signed (Month, Day, Year)

JANUARY 31, 2000



3. Tima of Death

2. Date of Death

State Registrar

31. Dete liled (Month, Dey, Year) FEB 0 2 2000

FRANCIS KHOO, M.D.,

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

29b. Signature and title of certifian

1. Decedent's Name (First, Middle, Last)

32. Registrar's Signature

Sports!

29c. License number

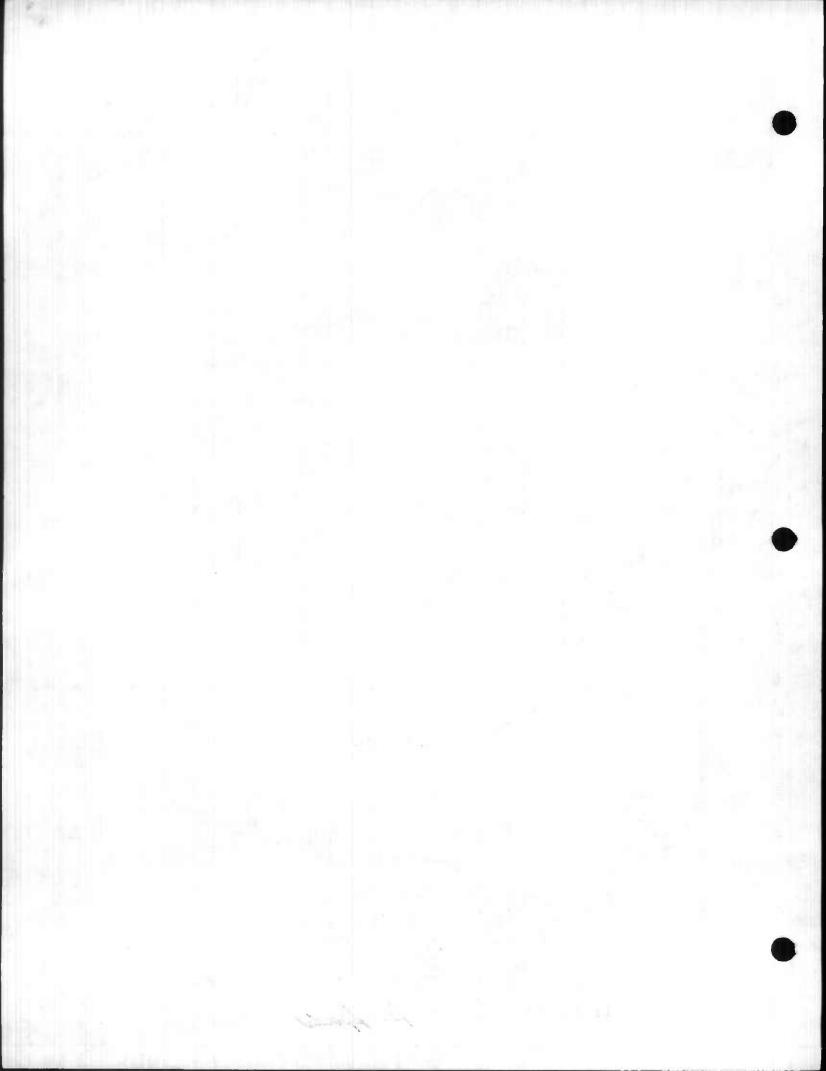
D30263

7601 OSLER DRIVE, TOWSON, MARYLAND

29d. Data signed (Month, Dey, Year)

01-28-00

21204

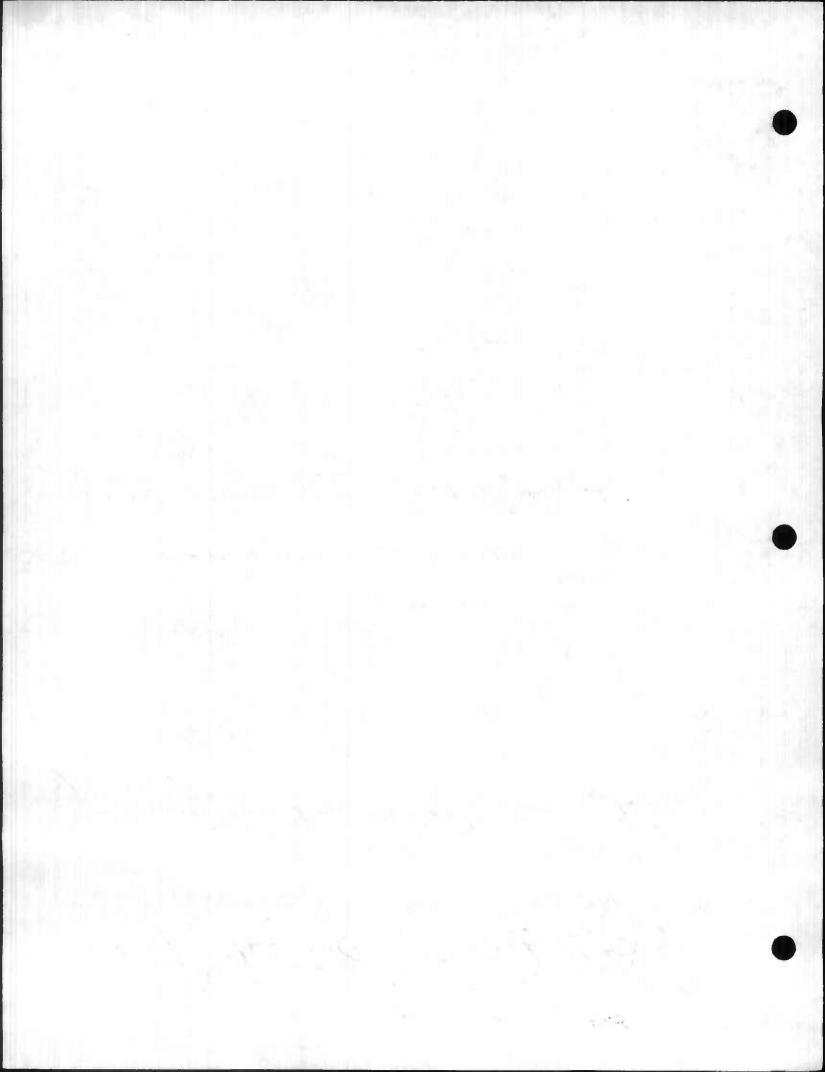


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State of Maryland / Department of Health and Mental Hygiene

| tment of Health and Mental F | lygiene | 00 | 01.1.0 | 0 |
|------------------------------|----------|-----|--------|---|
| ificate of Death | Reg. No. | 0.0 | 0446 | U |

| | | | | | Cer | rtificat | e of | Death | | R | eg. No. | 0 | 04400 | |
|--|------------------|---|--|---|----------------------|--------------------|------------------|---------------------|--|---|--------------------|--|--|--|
| | | 1. Decedent's Nama (First, Middle, La | st) | | | | | | | 2. Date of Dea | | Year | 3. Tima of Death | |
| Physic /Med | | MARY REGINA F | LORY | | | | | | | Jan. 1 | 9,2000 | T Gal | 6:00 AM | |
| Exami | | 4a Facility Neme (If not institution, giv Citizens Nursin | a street and num g Home | nber) | | 1 | | b. City, To Fred | wn, or L leri | ocation of Death C.K. | 4c. County Free | of Death ieric | | |
| Funeral Director | | 5. Social Security Number 6. S 216-60-7988 | Sex I□M 2√F | 7. Age (In yrs. last 82 | birthday) Yrs. | ff Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day Oct. 9, | Year) 1917 | 9. Birthr Cour Mar | pieca (Stata or Foreign http: 'Yland | |
| faryland show | or | Usuel Residence of Decedent 10a. State 10b. County MD. Frederi | ck | 10c. City, T | | cation svill | e | | | | | 1 | I 0d. Inside City Limits 1 ☐ Yes 2 🛱 No | |
| with the A a or 28a- | Director | 10e. Street and Number 10131 Kelly Roa | d | | | 10f. Zip | | 1793 | | 1 | 0g. Citizen of V | | ntry? | |
| 23 m | erai | | | dont Euros in 11 C | 12 1 | Man Doon | | | nin? /Co | anity Van ar Na | | | nan Indian | |
| 5-0020 72 hours after death with the Maryland natural, or florns 23a or 28a-f show neel Frank we must be incidined as | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed For 1 Tes If Yes, Give | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: | | | | Specify: | n, Puarto | ecify Yes or No- Rican, atc.) | Biad | ce - Americen Indian, ick, Whita, etc. fy: White | | |
| 72 hours | etec | 15. Decedent's Education (Specify only highest gra | ducation | 1 | 6a. Deced | dent's Usua | l Occup | ation during mos | t of work | ina | 16b. Kind of Bi | usiness/In | dustry | |
| 2121 d within glene. or then | Completed | Elemantary/Secondary (0-12) | College (1- 1 year | (Give kind of work done during most of wife. DO NOT use retired) Homemaker | | | | | . 01 ***01. | None | | | | |
| yland 2 ould be filed Mental Hygis arked other atic event, II | To Be | 17. Father's Name (First, Middle, Last, Frank Weller Fr. | | | | | | | me (First, Middle, Meiden Surnema) Mae Kelly | | | | | |
| Mar nd 2 sh ith and 27 is m | | 19e. Informant's Name/Reletionship (Douglas Flory | | | | | | | | re/Route Numbe kersvill | | | | |
| ballmore, amit. Pages 1 ar beatment of Hea mportant: If Nem; iny Injury or other | | 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 4 Donestion 5 Other (Specify) 20b. Piece of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery 1/21/00 Thurmont, | | | | | | | | | | | | |
| Balti permit. Departm Imports any lolu ance. | | 21. Signature of Pungral Service Licey | 1000 PM | en L | | | | | | SON FUN | | | | |
| _ | | 23a. Part1. Entar the disease, or com shock, or heart feilure. List only | nlications that ca | used the death. [| | | | | | | | | Approximata | |
| Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | | herosek Due to (or es | lesot | lic | | | | | | | Interval Between Onsal and Death | |
| and I-transit | xamine | Sequentially list conditions, | b | Due to (or as | e conseq | uence of): | | | | | | 1 | | |
| OX 68/60, n certificate be executed anding physician and use as the bunal-transit | Medical Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequence of): | | | | | | | | | | | |
| 0 - 5 - | lan | | | | | | | | | | | | | |
| that the deet ned by the etter detached for | Physician/ | Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4 | | | | |
| cords, | Completed by | | | | | | | | | 24a. Was a | | av | fere autopsy findings vailable prior to ompletion of ceuse deeth? | |
| The law ate has t | dwo | | | | | | | | | 1 D Y | es 2 No | | Yas 20 No | |
| VITAL I | | 25. Was cese refarred to medical | | | _ | | | 26 Plans | of Deel | th (Check only or | | | 7 | |
| | o Be | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | patient 2 ER | /Outnation | nt 3□ DC | Oth | . 1 . | | ome 5 Resid | | or (Speci | (Au) | |
| VISION OF Attending Physic death. ector: Attar this by the funeral d | - | 27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation | 28a. Dete o | | b. Tima of Injury | | 8c. Injur Wor | | | 28d. Describe h | | | 9) | |
| DIVISION C al or Attending P s after death. I Director: Attar it ed in by the funera | Certification: | 3 Suicide 6 Could not b determined | 9 Store of Jahren Asham Asham Asham Africa | | | | | | 28f. Location (S City or Tow | treet and Numb n, State) | oer or Run | al Route Number, | | |
| To the Hospital or Atternation 24 hours after de To the Funeral Directo completely filled in by the | edical | | | pest of my knowled sis of axamination or stoted. | | | | | | | | | | |
| To the Comp | X | 29b. Signetura and title of certifier | n | 1 | | 290 | Licens | e number | | | 19d. Date signe | d (Month, | Day, Year) | |
| | | X short. | Kay | Some | | 0 |) | -13 | 9- | 7/. | 1/20 | /20 | 000 | |
| | | 30. Name end address of person who | completed muse | of death (Item 23 | la) (Type, | Print) | | | - | | - | | | |
| | | ROBERT L. KAUFMA | | | | h Sti | eet | Fre | deri | ck, Md. | 21701 | | | |
| St Regist | ate rar | 31. Data filed (Month, Day, Year) | | gistrar's Signature | × M | *** | 600 | 11 | | | | | | |



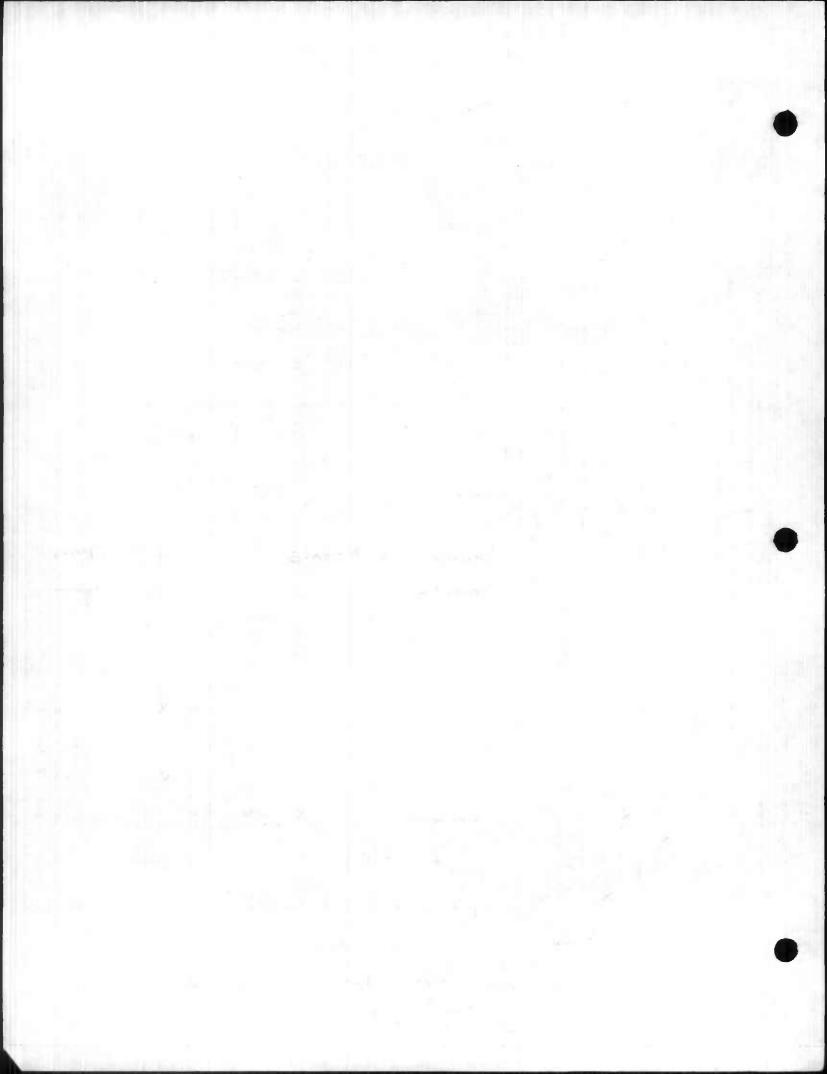
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** MARGARET Μ. FARRELL January 18, 2000 7:10 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 200 F Days Months Hours 81 Director 213-22-1065 30,1918 Dec. Maryland **Usual Residence of Decedent** the Maryland 10s State 10b. County 10c. City. Town or Location 10d. Insida City Limits show Maryland Frederick Frederick 1 Yes 2 No rms 23a or 25a-f a Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1497 hems 23a Dogwood Drive 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian. Black, Whita, etc. 1 Yes 20 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 1 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be illed w Department of Health and Mental Hygien Important; if Item 27 is marked other tha any Injury or other treumetre Registered Nurse Hospital 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Grover Cleveland Morgan Anna 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9506 Sylvan Dell / Columbia, Maryland Ann lawrence / daughter 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gard. 1-22-00 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, MD | 1041 Upossumtown fixe/ freque Embrithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Cause (Final PARKINSON'S envs DISEASE disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Demental physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, **Physician/Medical** Due to (or as a consequence of). P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? i certificata has b 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was casa referred to medical axaminer? 8 26. Place of Death (Check only one) 1 Yas 20 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertiling 29c. License number 29d. Data signed (Month, Day, Year) D4369/ 1-19-00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 801 Tou House Ave, Frederic MD SAEED CAID! 32. Registrapt Signature State 2000 Registrar



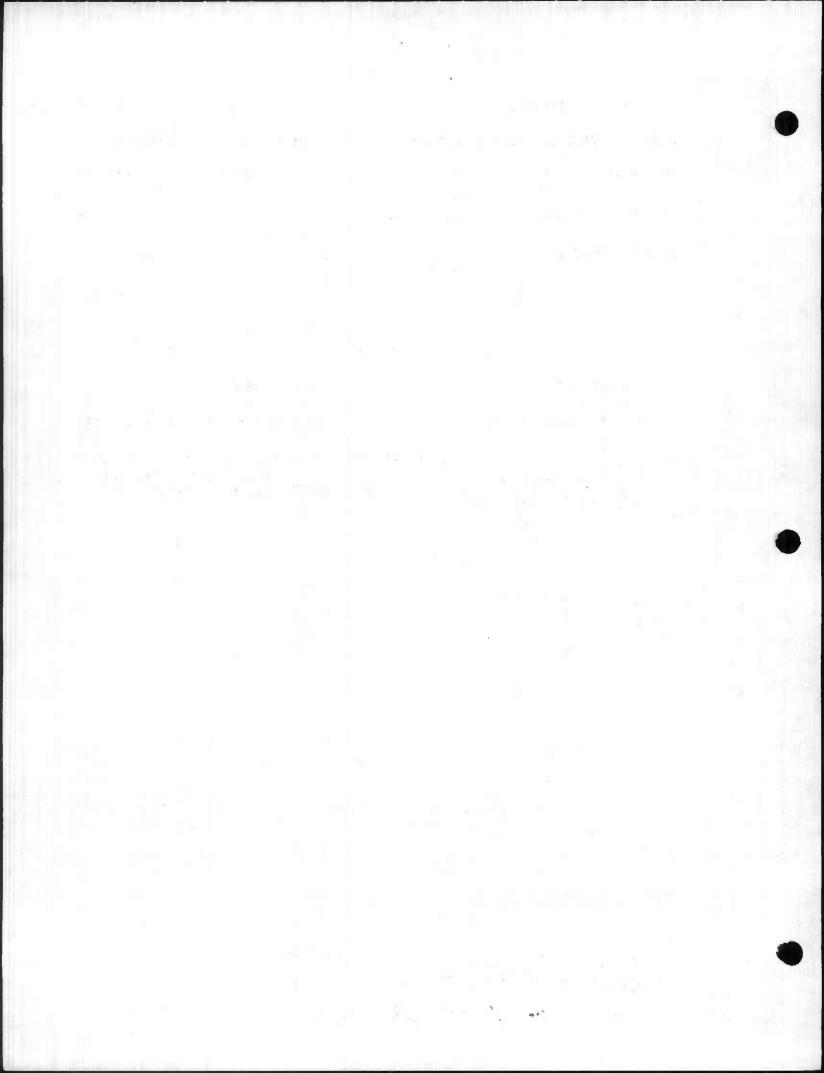
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00

| n al er | Decedent's Name (First, Middle, La: EDWARD M. GL 4a. Facility Name (If not institution, give | • | | | | | 2. Date of De | eth | | 3. Time of Death | |
|--|--|--|--|--|---|--|--|--|--|--|--|
| al | | ADDEN | | | | | Month | Day | Year | o. Tano or Doggi | |
| er | 4a. Facility Name (If not institution, give | | | | | | 1 | 29 | 00 | 10:10A.1 | |
| | | | | | | 4b. City, Town, or L | | | Carlotte and | | |
| | PENINSULA REGION | | | | Milliander d Ver | SALISBU | | | MICO | | |
| | 5. Social Security Number 6. S 213-22-6494 Usuel Residence of Decadent | ex ⊋M 2□F | 7. Age (In yrs. 70 | Yrs. | If Under 1 Yea Months Day | | 8. Data of Bir (Month, De 5-10-19 | rth ay, Year) 929 | 9. Birth | place (Stata or Forei ntry) LAND | |
| | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | 1. | Od. Inside City Limi | |
| ğ | MARYLAND WICO | MICO | FRI | JITLANI |) | | | | | 1 N Yes 2□N | |
| Director | 10e. Street and Number | | | | 10f. Zip Coda | | | 10g. Citizen of | What Cou | nlry? | |
| | 114 HAYWARD AVE. | | | | 218 | 26 | | USA | 1 | | |
| 2 | 11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorcad | Armed For 1 X Yes If Yes, Give | ces? 2 🔲 No | 1 | If Yas, specify Cuban, Mexican, Puerto Rican, etc.) | | | | ck, White, | | |
| jed P | | | | 16e. Deced | lent's Usual Occi | upation | cina | 16b. Kind of B | usinass/In | dustry | |
| ᇍ | Elementery/Secondary (0-12) | | 4or 5+) | life. I | OO NOT use retir | ed) | ang | Chile | CI | | |
| 5 | 12 | | 2 | MI | NISTER | | | Chor | CH | | |
| Re | | | | | | | | , Maiden Sumar | ne) | | |
| 0 | RALPH GLADDE | N | | | | DELIA HO | DRSEMAN | | | | |
| | The state of the s | | | | | | | | | | |
| - | | / DAUG | | | | DECATUR I | IWY., BI | ERLIN, M | D. 2 | 1811 | |
| | 1 Burlal 2 ☐ Cramation 3 ☐ | | tate | emetery, cren | netory or other pl | | Date -2-00 | | | | |
| 1 | 21. Signature of Funeral Service Ricen | M.C. | 2/ | 22 | Name and Add | ress of Facility MEL ATCHER ST. | SON FUN | ERAL SE | RVICI 1994 | ES,LTD. | |
| | Immediate Cause (Final diseasa or condition resulting in death) | a | Pne | rumon | 1a | | | | 1 | Interval Between Onset and Death | |
| Yalli | Sequentially list conditions, | b | Due to (or | ras a conseq | uenca of): | | | | | | |
| | Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) set | C | Due to (or | ras a consequ | ience of): | | | | | | |
| 3 | | d | | | | | | | | | |
| 0 | | | | | | | | | Î | | |
| | | | | | | | | | the cause of death bably 4 Unknow | | |
| nataldillo | hemachn | omatos | 515 | | | | 24a. Was | an autopsy ormed? | av. | ere autopsy findings allable prior to mplation of causa death? | |
| 5 | | 2 | | | | | 10 | Yes 20 No | 10 | Yes 2□ No | |
| | examiner? | | | | | | h (Check only o | one) | | | |
| 2 | 1 ☐ Yes 2 ☐ No | Hospital: | palient 2 1 | ER/Outpatient | 3LI DUA | 4 U Nursing Ho | me 5 Resid | denca 6 □Oth | er (Specif | v) | |
| 1000 | Netural 5 Pending investigation | (Month | Injury Day Year) | 28b. Time of Injury | | | 28d. Describe | | | | |
| | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined | me, farm, stre | et, factory, office | | | Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami | ner: On the bas | is of examinati | vledga, death ion and/or inv | occurred at the t estigation, in my | ime, date and place, opinion, deeth occurr | and dua to the red at the time, | cause(s) and madate and pleca. | and due to | ated. the cause(s) | |
| - 1 | 29b. Signature and title of certifiar | 1 | | | 29c. Lican | sa nu <i>m</i> ber | | 29d. Date signe | d (Month, | Day, Year) | |
| | C/ 18/1 | | | | DZ | 0853 | | 1/79 | 1/00 | | |
| | 30. Name and address of herson who o | ompleted cause | of death (Item | 23a) (Type 5 | Print) | 00/1 | | 1-8 | 00 | | |
| CACAL COLUMN COL | 10 be Completed by Funding | 11.4 HAYWARD AVE. 11. Marital Status 1 | 11.4 HAYWARD AVE. 11. Marital Status 1 | 11.4 HAYWARD AVE. 11. Marital Status 11. Marital Status 11. Never Married 2 Married 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) 12. College (1-4or 5+) 12. T. Father's Name (First, Middle, Last) RALPH GLADDEN 19a. Informant's Name/Relationship (Type, Print) MELODY G. TRAVERS / DAUGHTER 20a. Method of Disposition 15. Burlat 2 Cramation 3 Removal from State 4 Oonation 5 Other (Specify) 21. Signature of Funeral Service Dispose 22a. Part 1. Enter the disease or complications that caused the dealt shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Due to (or death) 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Mannes of Death 28e. Date of Injury (Month, Day Year) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examinat and manner stated. 29b. Signature and title of certifiar 30. Name and address of Serson who completed cause of death (Item Charles) 30. Name and address of Serson who completed cause of death (Item Charles) 30. Name and address of Serson who completed cause of death (Item Charles) 30. Name and address of Serson who completed cause of death (Item Charles) 30. Name and address of Serson who completed cause of death (Item Charles) 30. Name and address of Serson who completed cause of death (Item Charles) 31. Was and address of Serson who completed cause of death (Item Charles) 32. Was and address of Serson who completed cause of death (Item Charles) 33. Name and address of Serson who completed cause of death (Item Charles) | 11. Martial status | 11. Marital Status | 11. Marifal Status 12. Marifal Status 11. Marifal Status 12. Marifal Status 12. Marifal Status 12. Marifal Status 13. Marifal Status 13. Marifal Status 14. Marifal Status 15. Marifal Status 16. Do Not use reliably 18. Marifal Status 19. Mari | 11. Marrial Status 12. Was Decedant Ever in U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. Armed Forces of U.S. S. Decedent Status of U.S. S. Deceden | 11 Martia Status 12 Was Decededini Ever in U.S. 13 Was Deceded rising and Crigory (Specify Yes or No-Winder Forces) 16 Yes 2 No 16 Yes 2 No 17 Yes 2 No 18 Yes Y | 11 Martial Status 1 Mar | |

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Registrar DHMH 16 Rev 6/95

State



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State of Maryland / Department of Health and Mental Hygiene O O I. I.

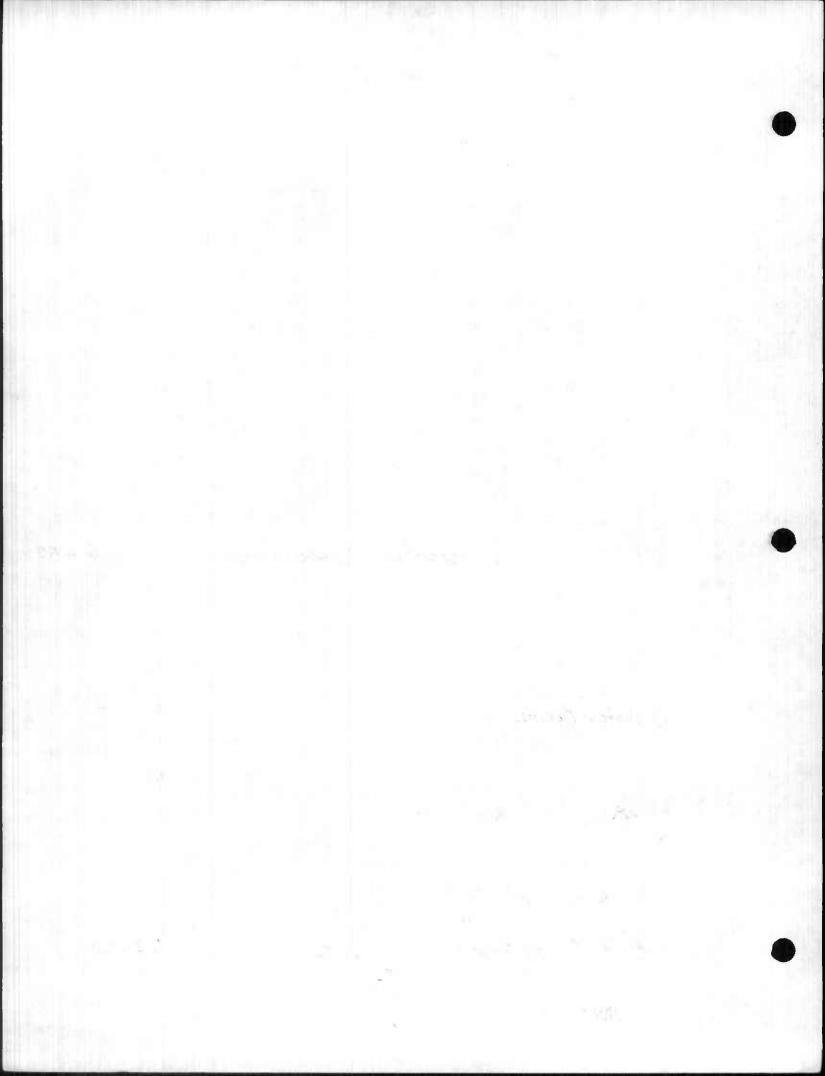
| | | | Ce | rtificate o | f Death | R | eg. No. | UU | 100 | | | | |
|---|---|--|--|---|---|---|----------------------------------|-------------------------------------|-------------------------------|--|--|--|--|
| Physician | 1. Decedent's Name (First, Middle, La | | | | | 2. Dete of Deal Month | Day | Year | Tima of Death | | | | |
| /Medical | HELEN PRETTY | MAN C | FALT | | | | 21,200 | 0 2 | 204 | | | | |
| Examiner | 4a Facility Name (If not institution, giv | e street and number) | | | 4b. City, Town, or I | | 4c. County | | | | | | |
| 94 | Memorial Hospi | | | T #44 4 4 4 4 | Easton | | Tal | | | | | | |
| Funeral Director | | O | ge (In yrs. last birthday) 38 Yrs. | Months Day | | 8. Dete of Birth (Month, Day) SEPT . 7, | | 9. Birthplece Country) DELAWA | (State or Foreign | | | | |
| P R | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Le | ocation | | | | 10d. le | nside City Limits | | | | |
| vith the Maryle t or 25s-f sho be notified at Director | | ALBOT | | | STON | | | | Yes 2 No | | | | |
| | 10e, Street and Number | | | 10f. Zip Code | | 1 | | What Country? | | | | | |
| eral mark | 501 DUTCHMAN'S L | ANE 12. Was Decedent | Ever in U.S. 12 | Was Decedent of | 001 f Hispanic Origin? (S | pacifu Vae or No. | USA 14 Bac | ce - American Ir | odian | | | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours after death vin and Merical Briginals of the marked other than "natural", or itsers 23 tresumstic event, the Medical Examiner mast To Be Completed by Funeral | 11. Marital Status 1 Never Married 2 Merried 3XXWidowed 4 Divorced | Armed Forces? 1 Tyes 2/0x If Yes, Give Year or Dates: | | If Yes, specify Co | uban, Mexican, Puert | o Rican, etc.) | | ck, White, etc. | | | | | |
| 1 21215-0 led within 72 ho tygiene. Ner then "neturn nt, the Medical.] Completed | 15. Decedent's Ed (Specify only highest gra | ducation ide completed) | 16a. Dece | dent's Usuel Occ | supation ne during most of wor | kina | 16b. Kind of B | usiness/Industr | у | | | | |
| T21 | Elementary/Secondary (0-12) | College (1-4or | 5+) life. | DO NOT use reti | red) | | | | | | | | |
| 121 year the | 12 17. Father's Name (First, Middle, Last) | -0- | PROP | RIETOR | 19 Mathada Nam | ne (First, Middle, I | | RY STOR | 8 | | | | |
| Be Be | JOSHUA PRETTYMA | | | | | | | пе) . | | | | | |
| trylar hould b d Ments marked marked To B | 19a. Informant's Name/Relationship (| ., | 10h Mail | ing Addrnos /Cho | SARAH net and Number or Ru | | SMITH | State Zin Cod | to l | | | | |
| Ma nd 2 s nd 2 s z le n | ANN BORDERS/ NIE | ** | | | DWARD AVE | | | | | | | | |
| Heal The | 20a. Method of Disposition | 023 | 20b. Place of Disp | osition (Name of | | | | City or Town, | | | | | |
| TO MADES | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif | | | matory or other p | 1 | | | | | | | | |
| Baltimore, emit. Pages 1 at Department of Nea moortant. If them 2 my injury or other size. | 21. Signature of Funeral Service Licer | | | ILL CEME 2. Name and Add | | 1-25-00 | EASTOR | N, MD 2 | 1001 | | | | |
| W SOFF | 6M 5 V | 1 11/ | FOD F | ELLOWS, | HELFENBEI | | | | ME, P.A. | | | | |
| | 23a. Part1. Enter the disease, or corn shock, or heart failure. List only | plications that cause | d the death. Do not en | 00 S. HA | ARRISON ST | EASTO | N MD 2 | | proximate | | | | |
| Physician | shock, or heart failure. List only | one cause on each li | ine. | | | | | Inte | rval Between set end Death | | | | |
| /Medical | Immediate Cause (Final | P | ncreat | | | | | 6 | wks | | | | |
| Examiner | disease or condition resulting in death) | . 100 | Due to (or as a conse | | MCINO. | ma | | | 007.3 | | | | |
| je i | | | Due to (or as a conse | quarica (v). | | | | | | | | | |
| 58760, cate be executed physician and the burial-transit afficial Examiner | Sequentially list conditions, Due to (or as e consequence of): | | | | | | | | | | | | |
| E EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | | |
| 68760, fleate be an in the burla | resulting in death) Last Due to (or as e consequence of): | | | | | | | | | | | | |
| Med pl | | | | | | | | | | | | | |
| P.O. BOX hat the death cel d by the attendir letached for use PhysicianA | d. | | | | | | | | | | | | |
| tha death yy the anched f | Part II. Other algnificant conditions of | ontributing to death b | out not resulting in the u | inderlying cause | given in Pert I. | 23b. Did to | obacco use co | ntributa to the | cause of death? | | | | |
| | Diabetes Mel | litus | | | | 1 U Y | 00 25 No | 3 Probably | y 4 Unknown | | | | |
| Vital Records, F sician: The law requires the certificate has been signed irector, page 2 should be de becompleted by F | | | | | | 24e. Was e | in autoney | 24b Were 8 | utopsy findings | | | | |
| Cord v requir been s should | | | | | | perfor | | availab | le prior to | | | | |
| Rec slaw has b | | | | | | | ~ | of deat | | | | | |
| Vital Relicion: The licion: The licion: The licion: The licion herector, page Be Com | | | | | | 1 🗆 Yı | | 1 □ Ye | s 2 No | | | | |
| of VIta Physician: this certific rai director, | 25. Wes case referred to medical examiner? | Hospitel: | | | Other | ath (Check only on | | | | | | | |
| T Se se se se se se se se se se se se se se | 1 Yes 2 No | 1 Inpation 1 28e. Date of Inju | | nt 3LI DOA | 4 LI Nursing H | lome 5 Reside | | | | | | | |
| On On After fune | 1 Natural 5 Pending | 28e. Date of Inju | y Year) Injury | W | ork? ☐ Yes 2 ☐ No | | | | | | | | |
| Division of the or Attending Physics after death. The following the funeral of t | 3 Suicide 6 Could not be | | jury - At home, ferm, st | | | 28f. Location (S | | ber or Rural Ro | ute Number, | | | | |
| DIV Bing | 4 Homicide | building, et | c. (Specify) | | | City or Town | n, State) | | | | | | |
| DIVIS To the Hospital or Atte within 24 hours after de vineral Directo completaly filled in by the Medical Certific | (Check only 2 Medical Exan | niner: On the basis of | of my knowledge, deat f examination end/or in | h occurred at the ivestigation, in my | time, date and place y opinion, death occu | , and due to the corred at the time, d | ause(s) and m late and place, | anner as stated and due to the | i. cause(s) | | | | |
| He R | one) 29b. Signature apartitle of certifier | and menner st | eted. | | nse number | | | ed (Month, Day, | | | | | |
| 0 1 × 10 0 | Separate and the distribution | -1.1 | / | | _ | | | | r varj | | | | |
| | 1/1 | mye | _ | 03 | 36909 | | 1-23 | .00 | | | | | |
| | 30. Name and address of person who | | | | | | | | | | | | |
| | CIICAN T FORTIFFI | 0 M D 5 | 05 DITTCUMA | 2 T / 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | 200 01 60 | 4 | | | | | | |

State Registrar

31. Date filed (Month, Day, Year)

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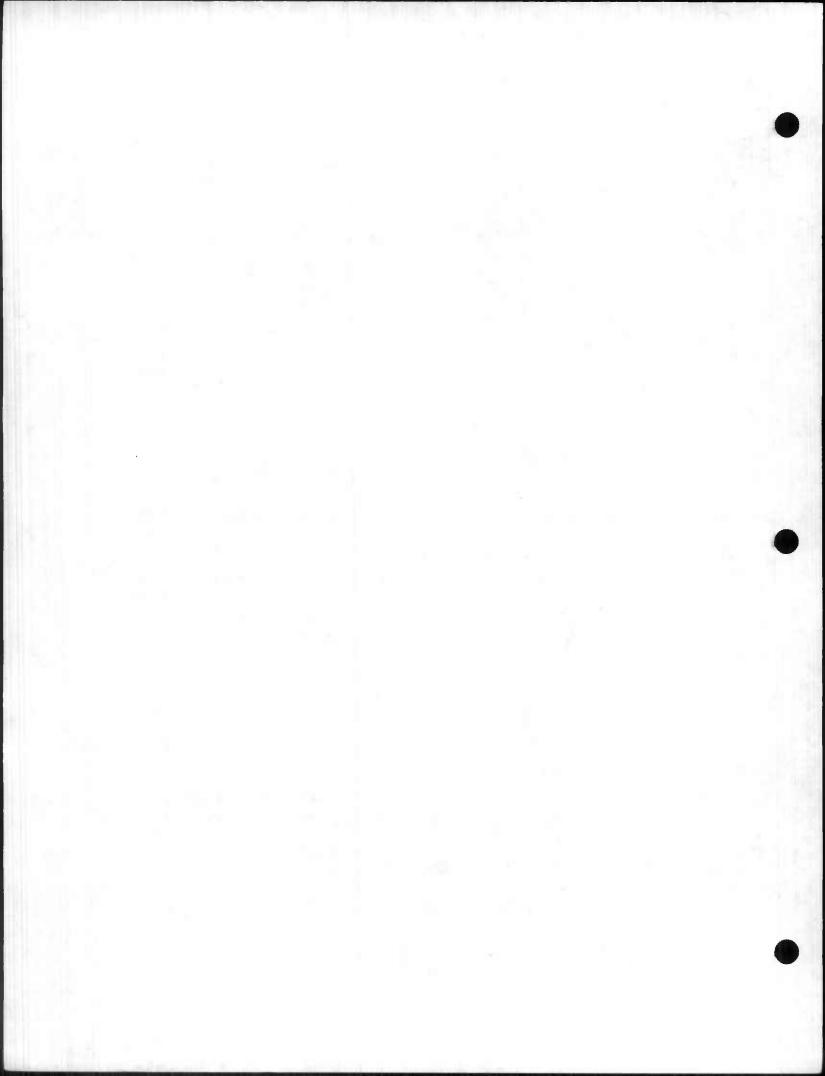
32. Registrar's Signeture



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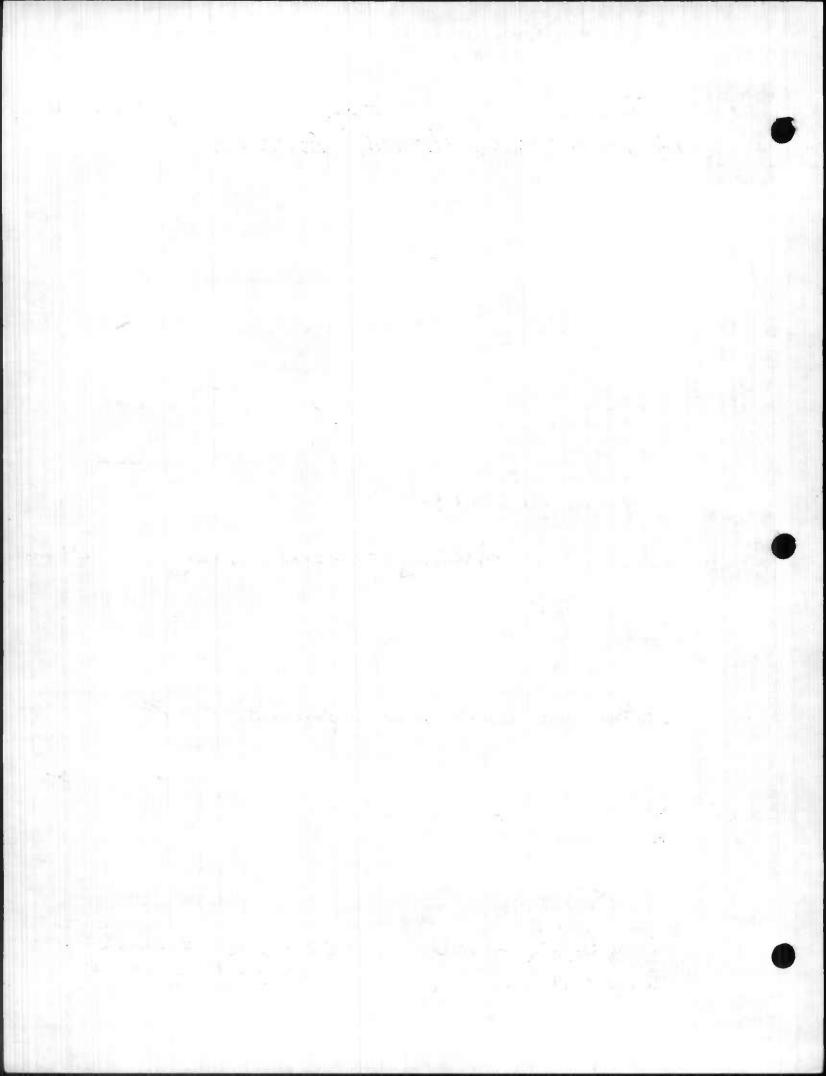
State of Maryland / Department of Health and Mental Hygiene 00 0446

| | | | | | Certificate of | of Death | R | eg. No. | | 7707 | | |
|--|----------------|---|---|--|---|--|---|-------------------|---------------------------|--|--|--|
| | | 1. Decedent's Nama (First, Middla, La | st) | | | | 2. Dete of Deat Month | h | Yaar | 3. Time of Death | | |
| Physicia /Medica | | Cody Joseph | Gallowa | ıy | | | January | 27, 20 | 000 | 8:00 a.m | | |
| Examine | | 4a Facility Nama (If not institution, gi | a street and number) | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | | |
| | | 25 Mountain Laur | el Court | | | Gaithers | burg | Montg | gomer | У | | |
| Funeral Director | | 5. Social Security Number 216-39-9714 | Sex 7. Age | (fn yrs. last bir | thday) If Under 1 Ya Months Da | | 8. Deta of Birth (Month, Day) July 24 | Year) , 1993 | 9. Birthp Cour Mary | ilaca (Stata or Foraig itry) Land | | |
| 2 | | Usual Rasidance of Decedant | | | | | | | | | | |
| how Lat | _ | 10a. Stata 10b. County | | 10c. City, Town | | | | | 1 | Od. Inside City Limits | | |
| M Ta | cto | Maryland Montgom | ery | Gaithe | ersburg | | 1 ☐ Yes 2 [] i | | | | | |
| with the Maryland a or 28e-f show the notified at Director | e l | 10e. Streel and Number | | | 10f. Zip Cod | a | 1 | 0g. Citizan of V | Vhat Cour | itry? | | |
| 23s w | | 25 Mountain Laur | el Court | | 20879 | | | United | Stat | es | | |
| after death with or flerns 23e or miner must be | Funeral | 11. Merital Stetus | 12. Was Decedent Ev Armed Forcas? | var in U,S. | 13. Wes Decedent | of Hispanic Origin? (Stuben, Maxican, Puerl | pecify Yas or No- o Rican, etc.) | | e - Amario | en Indian, atc. | | |
| D 1 1 1 1 1 1 1 | by | 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yas 2 🗓 No If Yas, Giva Year or Datas: | | 1□ Yas 2⊠i | | Specify | | Black/White | | | |
| Party | ted | 15. Decedent'a E (Specify only highast gr | | 16a. | Decedent's Usual Oc | cupation | kina | 16b. Kind of Bu | usiness/In | dustry | | |
| N S S S S S S S S S S S S S S S S S S S | Completed | Elementary/Secondary (0-12) | Collega (1-4or 5+ | | | na during most of work lired) | | | | Marin 12 S | | |
| Illed w Hygler ther th | Co | 1 | | Ne | ever Worke | | | Never Worked | | d | | |
| D d op the state of the state o | Be | 17. Fathar's Nama (First, Middla, Last | | | | | na (First, Middla, I | | | | | |
| aryidand should be fill not Mental H marked off imatic even | 2 | Willie Louis Mat | thews, Jr. | | | Colleen | Patrici | a Boggs | | | | |
| 2 sho | | 19a. Informant's Name/Ralationship | Type, Print) | 19b | Mailing Addrass (Str | eet end Number or Ru | ral Routa Number | , City or Town, | Stete, Zip | Code) | | |
| C S N L | | Colleen P. Gallo | way / mothe | r 25 | Mountain | Laurel Ct. | , Gaithe | rsburg, | MD | 20879 | | |
| 5 - 1 mg | | 20a. Mathod of Disposition | | Date 20c. Location - City or Town, Stata | | | | | | | | |
| month of the control | | 1 ☐ Burlat 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont | | | Disposition (Name of y, cramatory or other peake Crem | atory INC1 | /29/2000 | Beltsv | ille | . Marvlan | | |
| emit. Pa apartman sportant: ny injury 1558. | - | 21. Signature of Funeral Service/Liga | | 000000 | | | 1 | | | | | |
| o selen | | 1 for 11/1 | 11 | | Rapp Fun | drass of Fedility eral & Cre D. Lohrman Avenue, S | mation S | ervices | 3, | | | |
| | - | , , , , , , | | 0956 | 933 Gist | Avenue, S | ilver Sp | ring, N | lary1 | and 20910 | | |
| | | 23a. Part1. Entar the diseasa, or con shock, or haart failura. List only | ona cause on each lina | na death. Do r l. | iot antar the moda or | dying, such as cerdiac | or raspiratory arr | asi, | 1 | Approximata Intarval Batween Onsat and Death | | |
| Physician | | | | | | | | | 1 | Orisat and Death | | |
| /Medical Examiner | | Immediate Causa (Finel diseesa or condition resulting in daath) | a BRAIN TU | MOR PRO | OGRESSION | | | | | 1 YEAR | | |
| | _ | Toodking in dawny | D | ue to (or es a | consequence of): | | | | | | | |
| P 15 | Examiner | | b | | | | | | ì | | | |
| and tran | Хап | Sequentially list conditions, | D | ua to (or as a | consequence of): | | | | | | | |
| Sian Sian Surial | | Sequantially list conditions, if any, laading to immadiate ceuse. Entar Underlying Causa (Disaase or Injury | C | | | | | | | | | |
| death certificate be exacuted the saturation and of or use as the bunal-transit | edical | that initiated evants rasulting in daath) Last | | | | | | | | | | |
| | Me | | 4 | | | | | | | | | |
| Both cert attendin for use | a 2 | | d | | | | | | | | | |
| dea deaf | Physiclan/M | Part II. Other algnificant conditions | given in Pert I. | 23b. Did to | obacco use co | ntributa t | o the cause of death | | | | | |
| that the deal he a detached for | ١٤ | | | | | | 1 Y | as 2 No | 3 Pro | bably 4 Unknow | | |
| signed d be de | þ | | | | | | | | , | | | |
| | | | | | | | 24a. Was a | n autopsy med? | 24b. W | ara autopsy findings allable prior to | | |
| law requires been as been a 2 should | o e | | | | | | | | CC | mplation of causa death? | | |
| The law ste has | Completed | | | | | | 1 D Y | as 2 No | 1 | □Yas 21 No | | |
| Vitali delan: The certificate rector, pag | | 25. Was cesa referred to medical | | | | 26 Blace of Day | | | 1 | 3.00 | | |
| Physicien: The is this certificate he ral director, page | 8 | axaminar? 1 ☐ Yas 2 ☒ No | Hospital: | | | 0.1 | ona 5 Resid | | (C) | 4.4 | | |
| | 2 | 27. Magner of Death | | t 2 ☐ ER/Ou | thatient 30 DOX | 4 Noising (| 28d. Dascribe h | | | γ) | | |
| After funer | Certification: | 1 ☑Natural 5 ☐ Panding | 28a. Data of injury (Month, Day | Year) | | njuryat Work? 1 □ Yas 2 □ No | 2001 2000110011 | ,.,, | | | | |
| OIVISION or Attending after death. Director: After d in by the fune | Ca | 2 Accident invastigation 3 Sulcide 6 Could not be | | Albana fa | | | 291 Location /S | treat and Numi | or or Bur | al Route Number, | | |
| or Attendate deat Director: | 딑 | 4 Homicide detarmined | building, etc. | (Specify) | rm, streel, factory, off | Ca | City or Tow | n, Stete) | nor or right | ir riodio rvanico, | | |
| led as led | | V | | | | | L | | | | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | | nyaician: To the best of miner: On the basis of a | xamination an | | | | | | | | |
| the the | N O | 29b. Signatura and little of certifier | and mannar state | ou. | 200 1 in | anse number | | 9d. Date signe | d (Month | Day Year! | | |
| | - | 250. Signatura and fille of certifier | | | | | | | | | | |
| 3 | | T.MC | | | D | 0053909 | | January | 28, | 2000 | | |
| | | 30. Nema and addrass of person who | · · | | | | | | | | | |
| | | Tobey MacDonald, | M.D., 111 | Michig | an Ave., N | W, Washing | ton DC 2 | 0010 | | | | |
| State | e | 31. Date filed (Month, Day, Year) | 32. Begistrar | 's Signature | , - , | | | | | | | |
| Registra | ır | LEDT SO | 00 Sener | w L | 9. Soon | 61 | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04465. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** January 27, 2000 1231 -rene /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) Examiner SCHUS 8. Date of Birth (Mooth, Pay Year) JULY 13, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2OXF Months Days Hours Min 82 Duduesne. PA Yrs. 208-16-1825 Director Usuel Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23a or 28s-f ahow traumatic event, the Mooical Examinal must be notified as 1 Yes XX No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7812 Golden Pine Circle USA 21144 permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Haelth and Mental Hyglene.
Important: If item 27 is marked other than "natural" or hand hyllury or other traumatic events. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ≥ 2/2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes No Specify: Specify: 3 → Widowed 4 Divorced þ Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) City of Duquesne & Elementary/Secondary (0-12) College (1-4or 5+) Allegheny County Clerk 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) John Chatlos Theresa Salters 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward A. Anderson - Son 7812 Golden Pine Circle Severn, MD 21144 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/31/00 Joseph Cemetery Duquesne, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Capitol Funeral Service, Inc. 7211 Lee Hwy. Falls Church, VA and the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, occ. of heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting In death) hour Examiner Physician/Medical Examines The law requires that the daath certificata be executed physician and the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, thet initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a signed by t d be detech 1 Yes 22 No 3 Probably 4 Unknown valve replacement þ 24b. Were eutopsy findings avellable prior to 24a. Was an eutopsy Completed peen completion of cause of death? has 1 ☐ Yes No certificete 1 Yes 2 No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death funeral 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation or Attending in 24 hours effer deam.
The Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier Medical completely (Check only one) within 2 the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certific 0 January 27, 2000 RES-000 M.D 600 North Wolfe 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) maryland Salazar Baltimore Jorge 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 2000 Registrar



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| Physician | ŀ |
| /Medical | L |
| Examiner | I. |
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Funeral Director

the Meryland r 28s-f show with "natural", or itama 23a or e filed within 72 hours efter death will hygiene.
other than "natural", or itama 23a vant, the Mag cal Examinal must be .. Peges 1 and 2 should be filed w tment of Heelth end Mental Hygier tant: if item 27 is marked other th jury or other traumatic evant, the

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

and I-transit law requires that the death certificate be executed ettending physician a for use es the buriel-P.O. Box 68760 ed by the e signed b Division of Vital Records, been signature irector, page 2 s Physician: director, this funeral or Attanding efter death. Director: / in 24 hour. the Funeral Directhe Hospital

Certificate of Death 2. Date of Death 1 Decedent's Name /First Middle | ast) 3. Time of Death Day Marcelino G. Gonzales 2:20 AM January 28, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs. Hours | Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months | Deys Hours 1 X M 2 □ F Yrs 461-10-2418 91 Sept. 3, 1908 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 14720 Waterway Drive 20853 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Mexican Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic Automobile Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Not Available Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliette G. Trevino/Daughter 14720 Waterway Drive, Rockville, Maryland 20853 Date 31, 20b. Placa of Disposition (Name of cametery, crematory or other place) Important: If its any injury or oth 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 2000 4 ☐ Donetion 5 ☐ Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery 22. Nama and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Servica Licansee rele M0080300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Ю 23a. Fert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onset and Death Immediate Causa (Final Respiratory Failure disease or condition resulting in death) Dua to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of daath? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 ☐ Panding 1 X Natural 1 Yes 2 No investigation 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 Homicida 29a. Cartifian 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only Family 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 050809 2800

State Registrar 20

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

2000

Michele L. Marziano, M.D.

31. Date filed (Month, Day, Year)

Physilian

32. Registrar's Signature

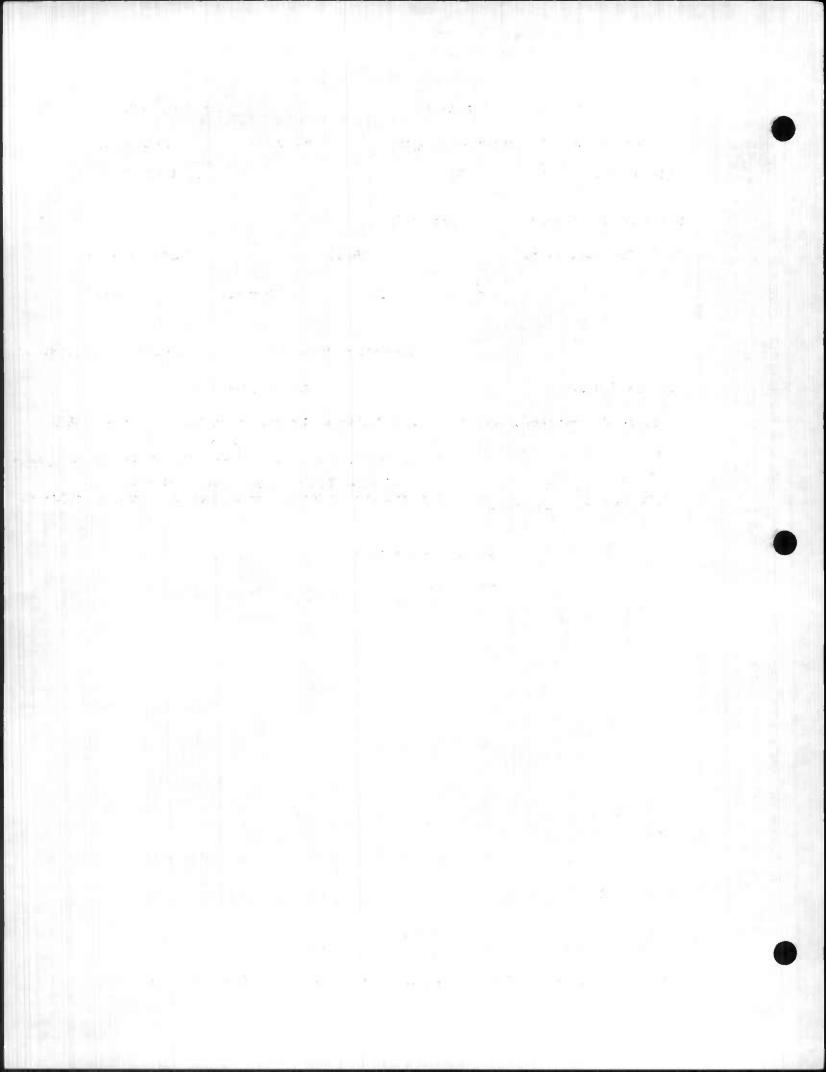
6111 Executive Blvd., Rockville, Maryland 20852

oak

DHMH 16 Rev 6/95

within 24 hor To the Fune completely fi

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 11 14 6 7 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** JAN. 27, JEAN RUTH GORDON 2000 1:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BRIGHTEN GARDENS N. BETHESDA 8. Date of Birth 07.05.1904 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 20 F 95 Director 117.38.5666 Usual Residence of Decede NEW YORK the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita show 1 ☐ Yas 2 No rs 23a or 28a-f al Director MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Norms 23a 20854 9017 CHERBOURG DRIVE Funeral 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 ahould be filed within 72 hours after observment of Health and Mental Hyglena. Important: If Item 27 is marked other than "natural", or lies any injury or other traumetic event. the Medical Franchow 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 WHITE 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å ESTHER SIMON LOUIS PLATT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 9017 CHERBOURG DRIVE, POTOMAC, MD 20854 LAWRENCE J. GORDON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1.28.2000 ST. ALBANS, NY OLD MONTEFIORE CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ONGESTIVE physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): 480 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown HRONIC Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 a 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

certificata of Vital Certification: To this Division

After Attending To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

27. Manner of Death

1 Neturel

2 Accident

3 Suicide

4 Homicide

6

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00

Muly Venuy MW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

9801 GEORGIA AVE, SUITE 227, SILVER SPRING, MD 20902 MERLYN K. VEMURY, M.D., Ph.D.

State Registrar

edical

31. Date filed (Month, Day, Year) JAN **31** 2000

5 Pending investigation

6 Could not be determined

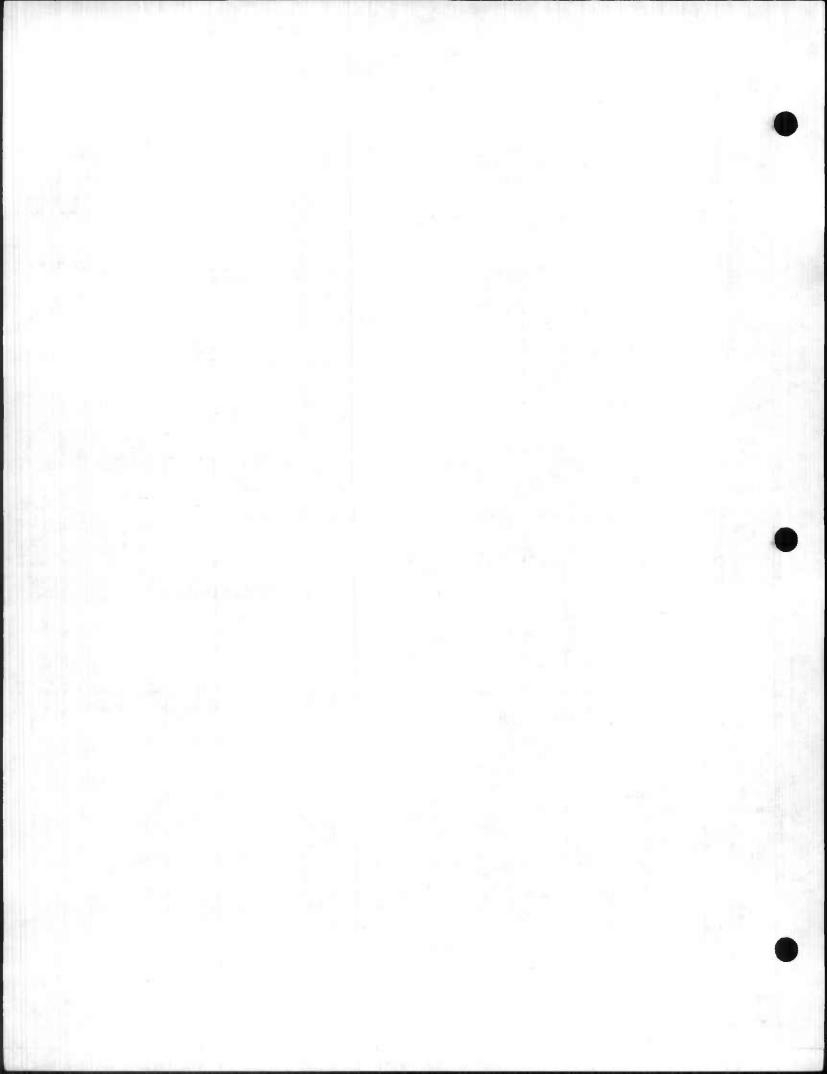


1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28b. Time of Injury

oaks



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. 04468 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** DOROTHY GROSSMAN FEBRUARY 01, 2000 8:57 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MONTGOMERY BRIGHTEN GARDENS BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 08.01.1905 5. Social Security Number 9. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2QF Yrs. 94 Director 182.01.1881 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show 77 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exertiner must be notified at 1 Yes 2 No Director BETHESDA MD MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 USA 5550 TUCKERMAN LANE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Bieck, White, etc. should be filed within 72 hours after und Mental Hygiene. marked other than "natural", or flee 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 2 No Specify: Specify: WHITE by 3 ☑ Widowed 4 □ Divorced Completed 16e. Decedent's Usuei Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementery/Secondary (0-12) Coilaga (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) is marked o CECILIA "UNKNOWN" BENJAMIN LIPSCHUTZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) # Health ar 11321 WILLOWBROOK DRIVE, POTOMAC, MD 20854 BARRY GROSSMAN/SON altimore, 20e. Method of Disposition 20b. Ptece of Disposition (Neme of cematery, crametory or other plece) Dete 20c. Location - City or Town, State Pages hent of h Department of Important: If it any injury or o once. 1 Buriat 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) KING DAVID MEMORIAL GARD. 2.4.2000 FALLS CHURCH, VA 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signeture of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one causa on each line. Approximate interval Between Onset and Death Physician tmmediate Cause (Final disease or condition rasulting in death) /Medical Examiner Due to (or as a consequence of): Examiner ettending physician and for use es the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury Due to (or as e consequenca of): Box 68760 Physician/Medical that initiated events resulting in death) Lest Due to (or as e consequence of): P.O. Pert It. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No signed by 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Wara eutopsy findings aveileble prior to complation of cause of daath? 24e. Was en eutopsy performed? Completed need certificate hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only ona) exeminer? Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: Nursing Home 5 - Residence 6 - Other (Specify) 10 27 Mapner of Death 28d. Describe how Injury occurred Certification: Naturei 2 Accident 5 Pending investigation 1 Yes 2 No 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 I Homicida 29a. Cartifier 1th Cartifying Physician: To the best of my knowledga, daath occurred et the time, date end place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) end manner stated. Medical (Check only one) 29d. Data signed (Month, Day, Yaar) 29b. Signature and talle of certifier 29c. License number LO

Ril Betherda MAD 20814

eddress of person who complated causa of death (Itam 23a) (Type, Print)

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04 2000

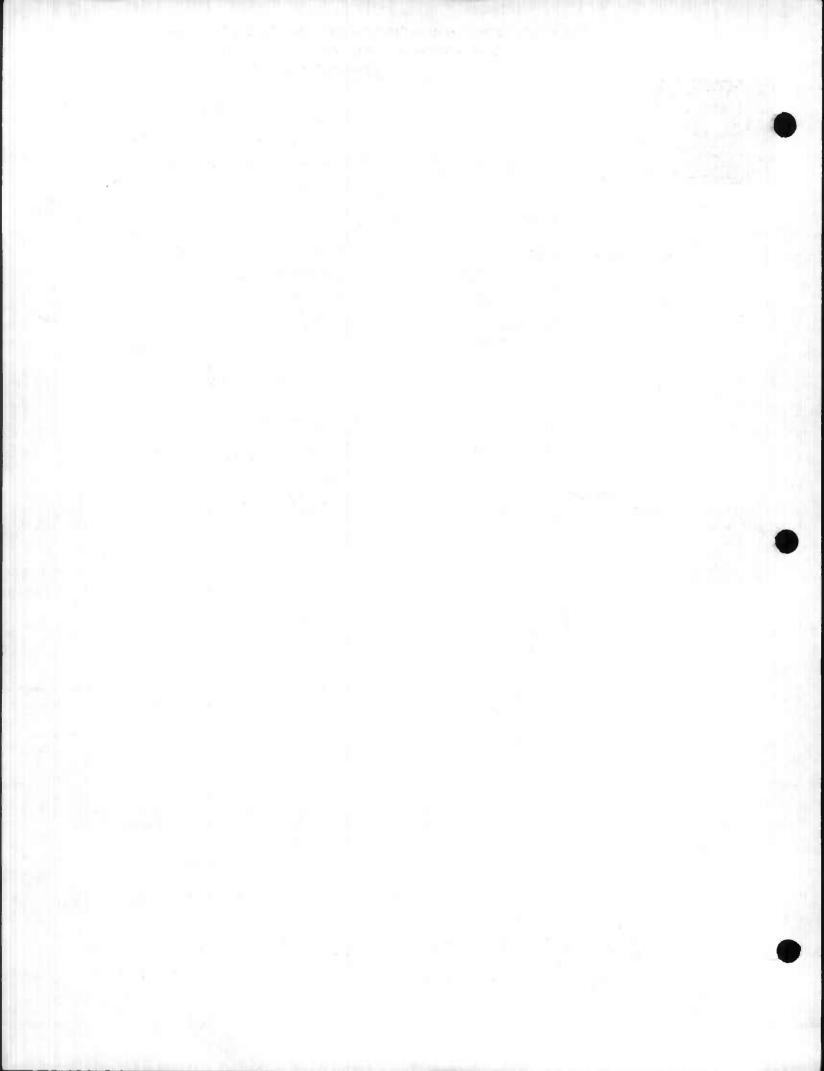
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4/0

32. Registrar's Signeture

6001

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04469 Amended Item#11 perInfg782 4/6/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** G. Guise 1:27PM Hazel 27,2000 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Wheaton Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Montha Days Hours 257-42-5548 1□M XX 69 Yrs. Director 9.1980 Georgia **Uaual Residence of Decedent** 10c. City, Town or Location 10d. Inside City Limits the Marylar 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flams 23a or 8103 Spaulding Circle 21144 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiens.
Int. If Item 27 is marked other than "retural", or its 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: White þ 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Public School 17. Father's Name (First, Middle, Last)

A. Bryant altimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Esma Wells 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if Item 27 is or other tre Susan Blair (daughter) 6758 BronzePost Rd. Centreville, Va. 20121 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 01d Canoochee Church 02/02/ 1 Burial 2 Cremation 3 Removal from State Swainsboro, GA. Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Fefferal Service Licensee 22. Name and Address of Facility Old Town Funeral Choices 205 Belle Haven Rd. Alex., Va. 22307 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Scleroderma disease or condition resulting in death) Examiner Due to (or as a consequence of): Sepsis Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last and bunial-tran Due to (or as a consequence of): Respiratory Failure Box 68760, physician Physician/Medical the the Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown by this certificate has been sign ral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No al or Attending Physicien: The safer death.

In Director: After this certificated in by the funeral director, page 100 and 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical

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Registrar

on the and address of person who completed cause of death (Item 23s) (Type, Print)

Dr. Eric Oristian, MD 2730 University Blvd. Wheaton, Md. 20902 31. Dale filed (Month, Day, Year) State

FEB 02 2000

Signature

29b.

32. Registrar's Signature Repeva

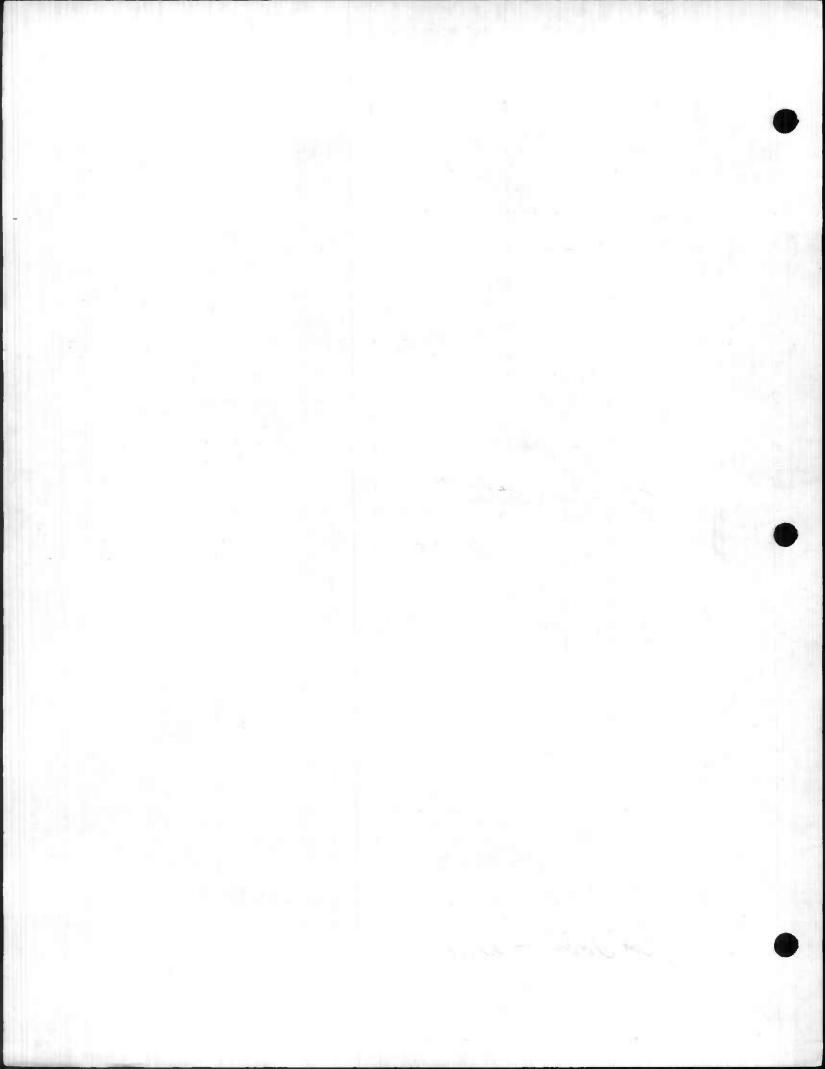
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29c. License number

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29d. Date signed (Month, Day, Year)

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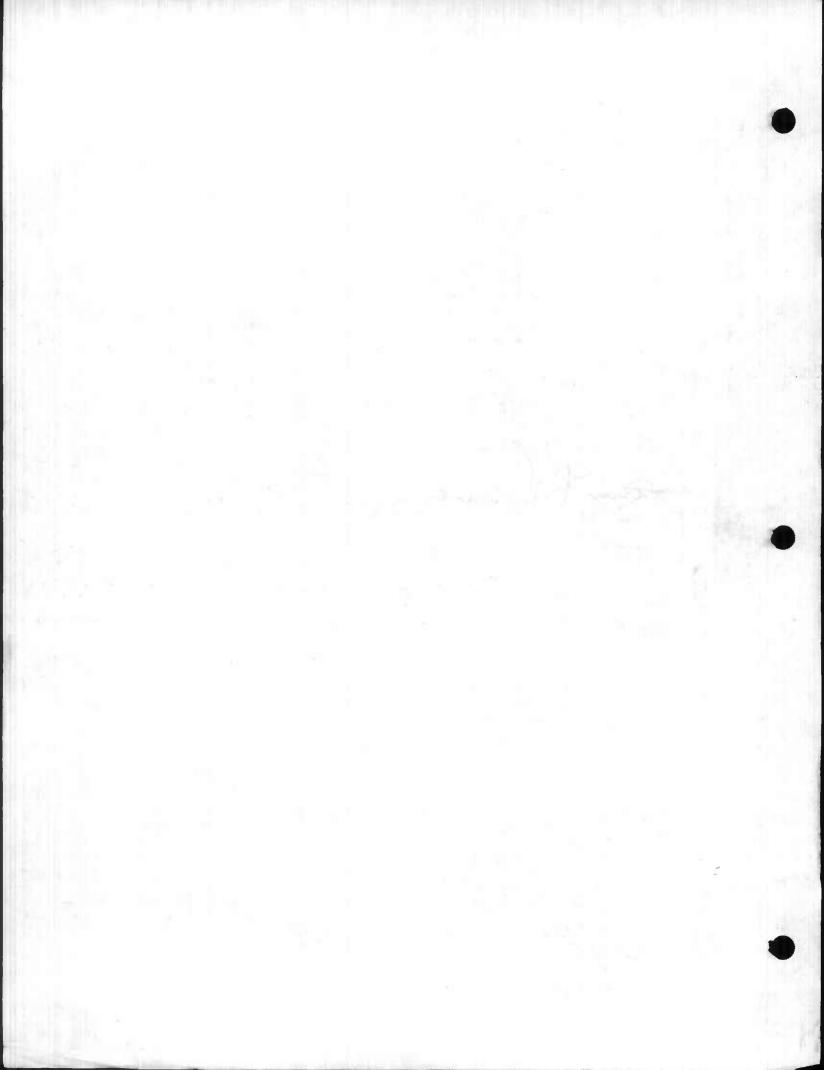


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Yaar **Physician** 29, 2000 JANUARY GUST EDWIN HARRY 2:45AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ 2□ F Months 302 01 6163 Yrs. Director OHIO 78 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haetth and Mental Hygiena. ant: if Itam 27 is marked other than "natural", or items 23a or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits if ham 27 is marked other than "natural", or hems 23s or 28s-f shot or other traumstic avant, the Modical Examinar must be nothed at 1 Yas 2 No FREDERICK FREDERICK Funeral Director MARYLAND 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21704 2742 RODERICK ROAD 12. Was Decedent Ever in U,S. Armed Forces?

1 ☑ Yes 2 ☐ No #Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: WHITE WWII Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOV'T. 12 ENGINEER Maryland 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) UNKNOWN UNKNOWN 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2742 RODERICK ROAD FREDERICK, MARYLAND GARY GUST / SON Baltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Fin Department of Important: If any injury or page. FALLS CHURCH, VIRGINIA 4 Donation 5 Other (Specify) 2/3/00 NATIONAL CREMATORY 21. Signature of Funeral Senior 22. Nama and Addrass of Facility NATIONAL FUNERAL HOME 7482 LEE HIGHWAY FALLS CHURCH VIRGINIA 22042 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laflyre. List only one cause on each line. Approximata Interval Between Onset and Death Physician disease or condition resulting in death) molnutulion /Medical nth Examiner Physician/Medical Examiner the attending physician and hed for use as the burief-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Box 68760, Due to (or as a consequence of): of Vital Records, P.O. After this certificate has been signed by the a funeral director, page 2 should be detached: Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Waa an autopsy performed? Be Completed 1 Yaa 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Horna 5 Rasidence 8 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

20 March Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 2-2-00 d address of person who completed cause of death (Item 23a) (Type, Print) MT. Airy Marylano 21771 RONALD CULWELL 6. 31. Date filed (Month, Day, FEB O 3 egistrar'a Signature State Registrar



Physician /Medical Examiner

certificate be executed physician and as the bunal-trans

Division of Vital Records.

permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 is m any Injury or other traum once.

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death in and Mental Hygiene. Is marked other than "natural", or itama 23.

Saltimore, Maryland 21215-0020

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25. Wes case referred to medical exeminer? 1 Yes 2 10 Mo 1 Maturel.

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28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

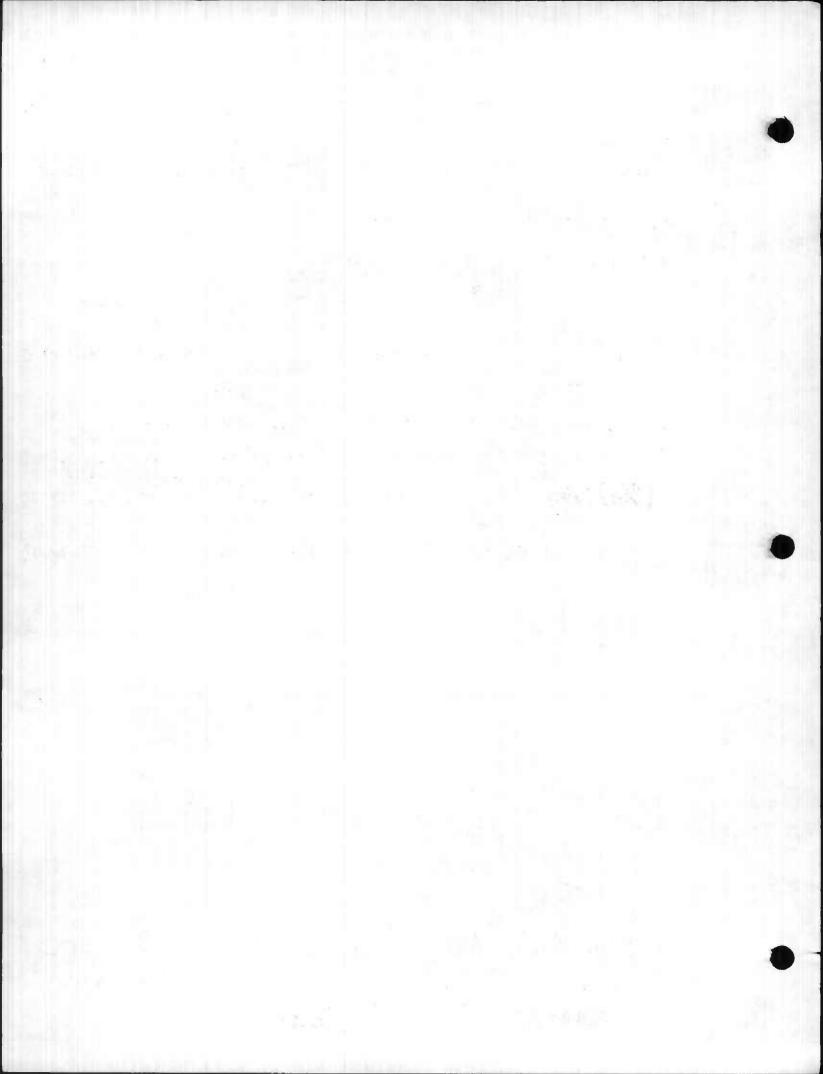
224 Washington Heights Westminster mid 21157 Flavio Kruter. 31. Dete filed (Month, Day, Year)

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 011172

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| 21215-0020 | urs a | by | 3 XWidowed 4 □ Divorcad | If Yas, Giv | e^\\as: | 1 | ☐ Yas 2X No | Specify: | | | | Specify: | B1a | .ck | |
| 0-0 | 2 ho | 8 | 15. Decedent's E | ducation | | 16e. Deced | ent's Usual Occu | upation | | | 16b. Kin | nd of Bur | sinass/inc | lustry | |
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| Maryland | should ind Men | - | 19e. Informant's Name/Reletionship | (Type, Print) | | 19b. Mallin | g Addrass (Stree | | | | | Town, ! | Steta, Zip | Code) | |
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| | To the Hospital o within 24 hours aft To the Funeral DI completely filled in | Me | 29b. Signature and title of certifier | and manne | ar stated. | 15 | 29c. Lican | sa number | | | 29d. Data | signed | (Month I | Day Year) | |
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| Physician /Medical | ROBER | | AVID | GOOD | FELLO | rtificat W | | | | 2. Data of De Month JANUAF ocation of Deat | Pay 19 | | 3. Time of Death | |
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| Examiner | AUTUMN | | iva street and number) DRIVE | | | | | MT. A | | Cation or Deat | | ERICK | | |
| uneral rector | 5. Social Security 225-78-7 Usuat Rasidence | 845 | Sex 1 M 2 F 7. Age | 9 (In yrs. Is | est birthday Yrs. | If Undar Months | | If Undar Hours | Min. | 8. Data of Bir (Month, De Aug 2, | th ay, Year) 1963 | | 9 Birthplace (State or Foreign Country) Washington, D. C | |
| *natural', or items 23a or 28a-f ahow exites Examiner must be notified at letted by Funeral Director | 10a. Stata | 10b. County | ick | | Town or L | | | | | | | | 10d. Inside City Limits 1 X Yas 2 No | |
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| marked o | Robert | R. Good | fellow | | | | | Car | olvn | | Ke | ech | | |
| E E | t9a. Informant's | Name/Relationship | (Type, Print) | | 19b. Mail | ing Addrass | (Straat | | - | al Routa Numb | | | p Coda) | |
| 27 la r tran | Mr. & Mr | s. Robert | Goodfellov | V | 275 | Point | Far | m. Ta | gsbo | ro, Del | aware | 1993 | 9 | |
| nt: If item ry or othe | | | Ramoval from Stata | | ace of Disp matery, cra | osition (Nem metory or o | na of othar plac | ce) | | Data / 23/00 | 20c. Location | on - City or T | own, Stata | |
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State Registrar

31. Data filed (Month, Day, Year) MAN 2 1 2000 111 Penn Street, Baltimore, Maryland 21201

29c. Licansa number O.C.M.E

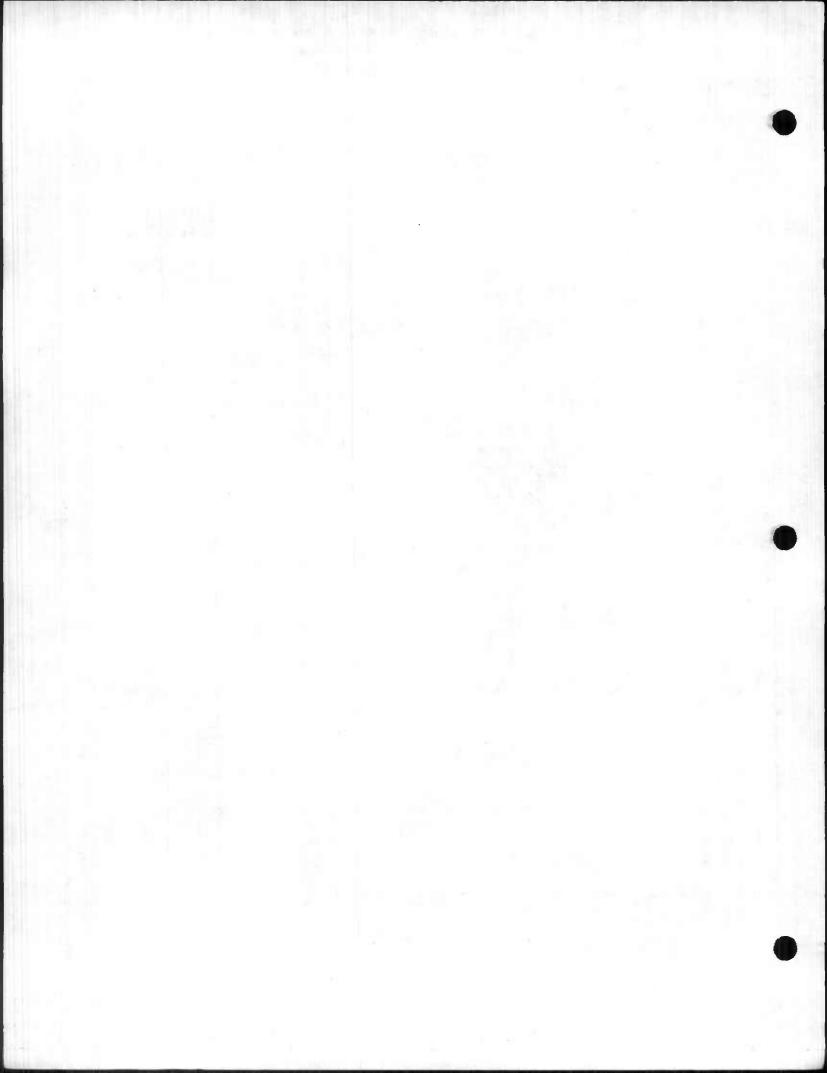
29d. Data signed (Month, Day, Year)

JANUARY 19,2000

A STANDARD SINGTON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 18, 2000 6:20 pm Robert Richard Greene /Medical 4a Facility Name (If not institution, give street and number)
147 Kline Blvd. 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth
Month, Day, Year)
1928 9. Birthplace (Stata or Foreign Country) 5. Social Security Number 216-22-5150 6. Sex **Funeral** Deys 11XM 2□ F Months Director Usual Rasidence of Decedent the Marylend a. State 10b. County Maryland Frederick 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hame 23s or 28s-f show the Medical Examiner must be nothed at Frederick 1 Yes 2 No Director 10e. Street and Number 147 Kline Blvd. 10g. Citizen of What Country? 10f. Zip Code 21701 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after Hygiene. ther than "netural", or the 1 Never Married 2 Married 1 Yes 2 No if Yes, Give Year or Dates: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of feath end Mental Hyglens Important: If tem 27 ie marked other tha any fillury or other traumatic event, the 1 page. Sales Manager Business Systems Sales 17. Father's Nama (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumamel Be John Virgil Greene Helen Eckman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 Kline Blvd., Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print)
Mary Ann Greene/Wife 20b. Place of Disposition (Name of Street Place), Inc. Jan. 21, 20c. Location - City or Town, State Street Place), Inc. Jan. 21, 2000 Frederick, Md. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, M00021 Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Malnutrition Examiner Due to (or as a consequence of) Examiner ung Cauce physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown Caucer by 24b. Were autopsy findings avsilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Fungal Infections 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phi within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by tha funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier D41866 January 19, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Tollhouse Avenue, D-3, Frederick, Maryland 21701 Kanan Hudhud, M.D., 31. Date filed (Month, Day 32. Registrayts Signature State 2 0 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death CLARA MARGUERITE 31, GUADAGNOL I JANUARY 2000 5:05 AM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Dec. 19, 1901 5. Social Security Number 079-01-2913 7. Aga (In yrs. last birthday). 98 Yrs. 9. Birthplace (State or Foreign New York 6 Sex Months 1 M 20XF Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits New Rochelle Westchester New York 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10805 U.S.A. 50 Highland Ave. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) School School Cafeteria Manager 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
50 Highland Ave., New Rochelle, New York, 10805 19a. Informent's Neme/Reletionship (Type, Print) Mrs. Clara Raffio, Daughter 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Holy Sepulchre Cemetery, Feb. 4, 2000 New Rochelle, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Keeney and Basford PA Funeral Home John MO0255 (ichay) 106 East Church St., Frederick, Md. 21701 ations thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line 23a. Part1. Enter the disease, or complication shock, or heert feilure. List only one call Approximate Interval Between Onset and Deeth Immediete Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Mmohia 24b, Were autopsy tindings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 20 No 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Deatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examine

Physician

/Medical

Examiner

Director

Funeral

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Name 23e

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permit. Pages 1 and 2 should be filled within 1 Department of Health and Mental Hygiene Importanti it fem 27 is merited other than "n any injury or other traumatic evant the land.

72 hours after

Baltimore, Maryland 21215-0020

Examiner The law requires that the death certificate be axecuted physician and the burial-transit P.O. Box 68760. Physician/Medical signed by the all d be detached for Records. Completed by certificate Division of Vital or Attending Physician: director, Be Certification: To this After death. n 24 hours after death we Funeral Director: A pletaly filled in by the f

Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Wes casa refarred to medical 1 ☐ Yes 2 ☐ 16 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 1 Satural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide McCordifying Physician: To the best of my knowledge, deeth occurred et the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier

State Registrar

completaly

Medicai

(Check only one)

29b. Signatury and title of certifier

the address of person who comp

32. Registrer's Signature 31. Dete tiled (Month, Day, Year) JAN 3

d cause of death (Item 23a) (Type, Print)

Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Md. 21701

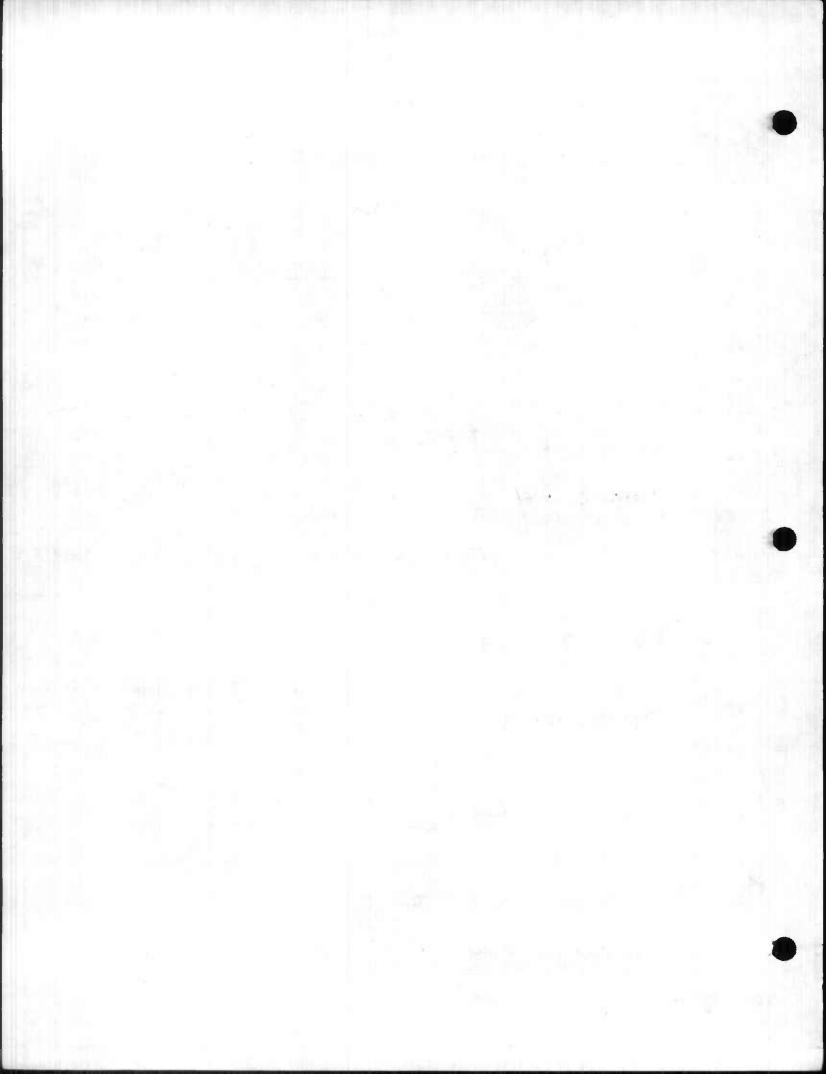
29c. License number

D 16428

29d. Date signed (Month, Day, Year)

Hospital

To the To the To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 01,476 Certificate of Death 1. Decedant's Nema (First, Middla, Last) 3. Time of Death 2. Date of Death Month etty Humple 8:30 pm ucille 00 4a. Facility Nama (If no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Hospita Lounty General CANOLI If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax Birthplaca (Stata or Foreign Country) 212-30-2509 1 M 2 XF Months 68 Yrs. Dec 13 1931 Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Carroll Westminster 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 70 S. Church St. USA 21157 11. Marital Status 12. Was Dacedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Marriad 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 📉 No Specify: **SpecifyWhite** 3 ☐ Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupation 16b. Kind of Buainass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elamentery/Secondary (0-12) Collaga (1-4or 5+) nursing assistant health care 4 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Elbert Holt Thelma Willis 19e. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert Humple (son) 167 Klees Mill Rd., Sykesville, Md 21784 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Sharon Baptist Cemetery 1-26-2000 West Friendship, MD 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Haight Funeral Home & Chapel Parge Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death bstructive Pulmonary Disease Immedieta Ceusa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of) Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 26. Pla

Physician /Medical Examiner

The lew requires that the death certificete be executed

certificate

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a. Stata

Md

Director

Funeral

by

Completed

Funeral

Director

the

item 27 is marked other than "natural", or itema 23a or 28a-5 show other traumatic event, ma Medical Examinar, must be notified at

permit. Peges 1 end 2 should be filled within 72 hours efter to Department of Health end Mentel Hygiene. Important: if item 27 is merked other than "natural", or then any injury or other traumatic event, ma Medical.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner physician end the buriel-tran Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or injury that initiated avants rasulting in daeth) Last Completed by Hospital or Attending Physician: T 4 hours efter death. Funeral Director: After this certificat tely filled in by the funeral director, po 25. Was case refarred to medical axaminar? Be Hospital: 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Deta of Injury (Month, Day Year) 27. Menner of Death 5 Panding Invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, acc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or Invastigation, in my opinion, d and manner steted. edical 29a. Certifiar (Check only onel 29b. Signature and title of certifier 29c. Licansa number

30. Nenw and addrass of person who complated cause of deeth (Itam 23a) (Type, Print)

455

| | 1 🖫 🗸 00 2 □ No | 3 Probably 4 Unknown |
|-----------|---|--|
| | 24a. Was an autopsy performed? | 24b. Wara autopsy findings available prior to complation of causa of death? |
| | 1 ☐ Yas 2 ☑ No | 1 Yes 2 No |
| ce of De | ath (Check only one) | |
| Nursing I | Homa 5 ☐ Rasidance 6 ☐ Oth | ar (Specify) |
| □No | 28d. Dascribe how Injury occur | red |
| | 28f. Location (Street and Numb City or Town, Stata) | per or Rural Routa Number, |
| | a, and due to the cause(s) end me urred et the time, dete end plece, | |

29d. Data signed (Month. Dav. Year) 1-24-00

Westminster, MD 21157

State Registrar

Robert 31. Dete tiled (Month, Day, Year) JAN 3 1 2000

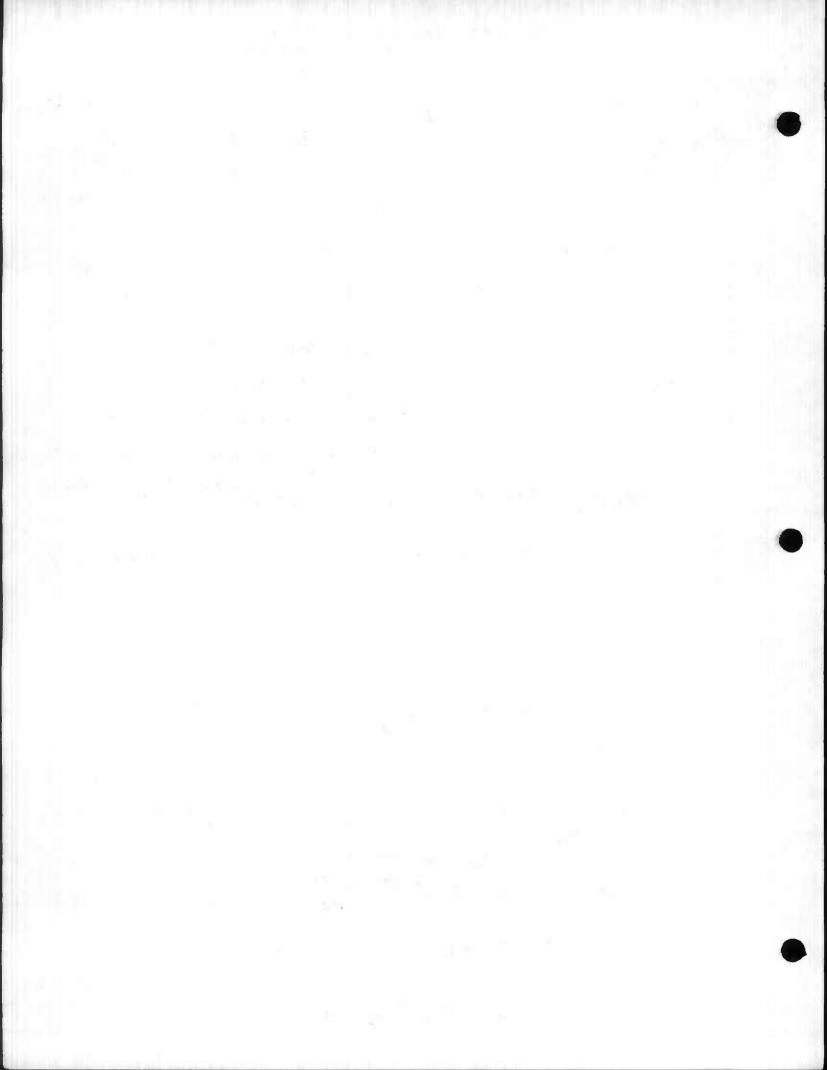
532 32. Registrer's Signatura

Baltimore Blud #201

Other: 4 🗆

1 Yas 2

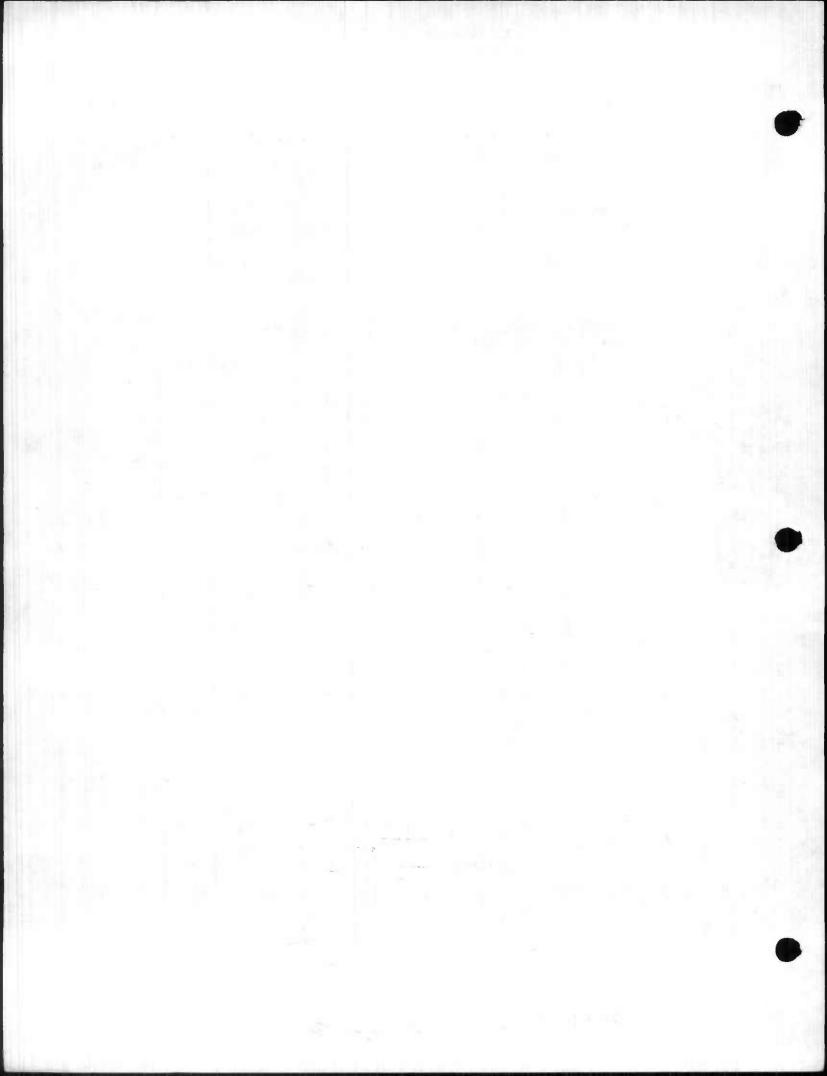
Injury at Work?



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month **Physician** Ruth 2000 1309 25 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 201F 579-12-0486 84 Yrs. July 28 1915 Washington DC Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f ahon must be notified at Md Carroll Sykesville Director 1 OYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 7309 Second Avenue 21784 USA items 23a Funeral Peges 1 and 2 should be filed within 72 hours after deeth nent of Health end Mental Hyglene.
Int: If hem 27 ie marked other than "natural", or itema 23, Iry or other traumatic avent, the Medical Estaminal must 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Deles: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown 12 Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Raletionship (Type, Print) Caregiver 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Continuum Care Medical records 7309 Second Ave., Sykesville, Md 21784 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Department or Important: If eny injury or once. Mt. View Cemetery 1+28-2000 Marriottsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Haight Funeral Home & Chapel Daige Haight Sterbert P.O. Box 195 Sykesville MD 21784 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Aspiration 9 d- ys /Medical Immediete Causa (Final disease or condition resulting in death) Examiner Completed by Physician/Medical Examiner The lew requires that the deeth certificate be assecuted Sequentially tist conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? After this certificate hes 1 Yes 25 No 1 ☐ Yes 2 ☐ No or Attending Physicien: funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number > parts J. Mon, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rabart L. Mars 114 Brinary Center Drive Reinford form, MI 21176 Robert L. Mors 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

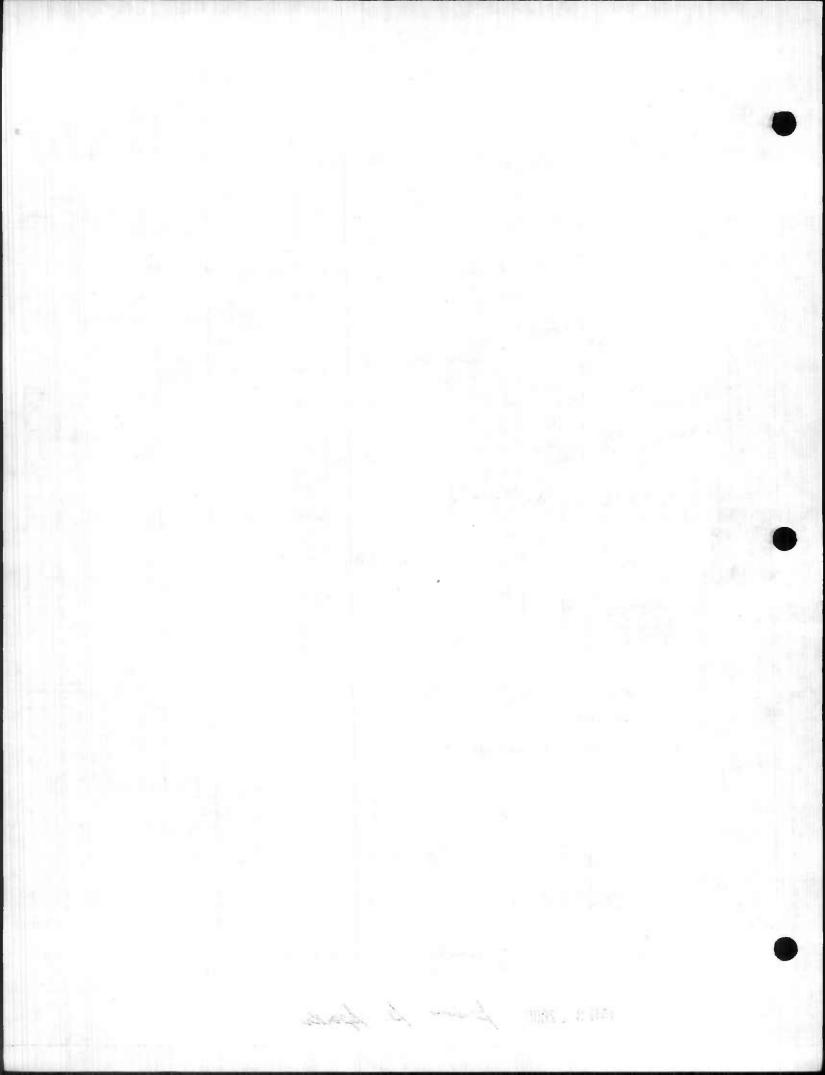


| | | Decedent's Nar | me (First, Mic | ddle, Last |) | | Ce | HillCall | e or i | Death | | 2. Data of E | | | Veer | 3. Time of Death |
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| niner | 48 | Facility Nama | (II not matitu | | | umber) | | | 1 | | - | TORE | 101 4G. | . County | of Death | |
| al or | | Social Security | Number | 6. Se | | | yrs. last birthday 72 Yrs. | (y) If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Data of B (Month, L Mar . | lirth Day, Year) 20, 1 | 927 | 9. Birthp Cour Nort | place (State or Foreign htry) th Carolina |
| | - | ual Residenca 1. State | of Decedent 10b. Cour | nty | | 100 | c. City, Town or I | Location | | | | | | | 1 | Od. Inside City Limits |
| Director | Ma | ryland | | Carro | 011 | | | Uı | nion | Brio | dge | | | | | 1 ☐ Yes 2 ₺ No |
| į | 100 | Street and N | umber | | | | | 10f. Zip | Code | | | | 10g. Cit | tizen of V | What Cour | ntry? |
| | | | Hoff R | | 40 W - D | | - 110 | | | 2179 | | | | | S.A. | an India |
| | | Marital Status 1 Nevar Mar 3 Widowed | rried 2 M | larried | 12. Wes Dec Armed F 1 X Yes If Yes, G Year or I | orces? 2 No live | 945-46 | If Yes, spec | | Specify | | ecify Yas or P Rican, etc.) | 10- | | ck, White, | can Indian, etc. ite |
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| | E | Elementary/Sec | condary (0-12 | 2) | College 5+ | (1-4or 5+) | life. | teach | | 1) | | | pub | lic | scho | 01 |
| | 17. | Father's Neme | First, Midd | le, Last) | | | | teaci | ile1 | 18. Moth | er's Name | (First, Midd | - | | | |
| | | Laytor | n W. H | o1cor | nbe | | | | | F. | Mar | ion Ot | ley | | | 2.1.23 |
| | | e. Informant's ? elly L. | | | | | | Box | | | | ni Route Num | | | | Code) |
| | - | . Method of Di | | / uai | agnicei | | Ob. Place of Disc | position (Nam | ne of | | lepne | rdstow | 1 | | | own, Stete |
| | | 1 Burial 2 | | | | State (| cometery, circlarroll | | | | . 1 | /28/00 | Ham | pste | ad, l | MD |
| | 21. | Signature of F | | | | 6.7 | 50 , | 22. Nama and | d Addres | ss of Facili | ity Har | tzler | Fune | ral | Home | 701 |
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| /Medical Examiner | See if a car | shock, or he mediate Cause ease or conditi | ert failure. Le (Final ion) conditions, immediate derlying or injury its | or complist only or | A A | Due | AYOLA | equence of): | le of dyin | In FA | cardiac | or respiretory | errest, | | D 21 | Approximate Interval Between |
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DHMH 16 Ray 6/95

STANLE YW.

HOLCOMBE,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Holland 2000 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Nursing + Kehab Center Snow HIII Worcester If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 F Days 219-07-4169 90 8/14/1909 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 South Church St Apt. 102 21863 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married White 1□ Yes 2No 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Shirt Factory 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Malden Sumame) Clarence Johnson Margaret Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21849 19a. Informant's Name/Relationship (Type, Print) Estel Holland (Son) 32052 Morris Leonard Rd. Parsonsburg, MD

Spring Hill Cemetery 2/2/00

22. Neme and Address of Fecility

20c. Location - City or Town, State

Girdletree, MD

21851 imate tnterval Between Onset and Death

Dete

Holloway Melson Funeral Home, P.A.

5302 CHINABERRY DR., SALISBURY, MD 2180

Physician /Medical

Physician

/Medical

Examiner

Director

Funerai

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Completed

10a State

20e. Method of Disposition

21. Signeture of Fune ai Service Licensee

Burial 2 Cremetion 3 Removal from Stete

Dean

30. Nama and aderass of person who complated cause of daath (Item 23a) (Type, Print)

BELLOSO

LOSO MD.

32. Registrar's Signatura

MOIJ29

Funeral

Director

orant: If rem 27 is marked other than "natural", or items 23s or 28s-f show Injury or other traumatic event, the Medical Examinator countried at

permit. Pegas 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frems 23a any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

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Examiner

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peen :

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

page 2 certificate

Box 68760.

Records, P.O.

Division of Vital

Physician/Medicai Be Completed by To Certification:

immediate Cause (Final disease or condition resulting in death) Sequantially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24s. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 25. Was state referred to m 26. Place of Death (Check only one) Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1st Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

20b. Place of Disposition (Name of cemetery, crematory or other place)

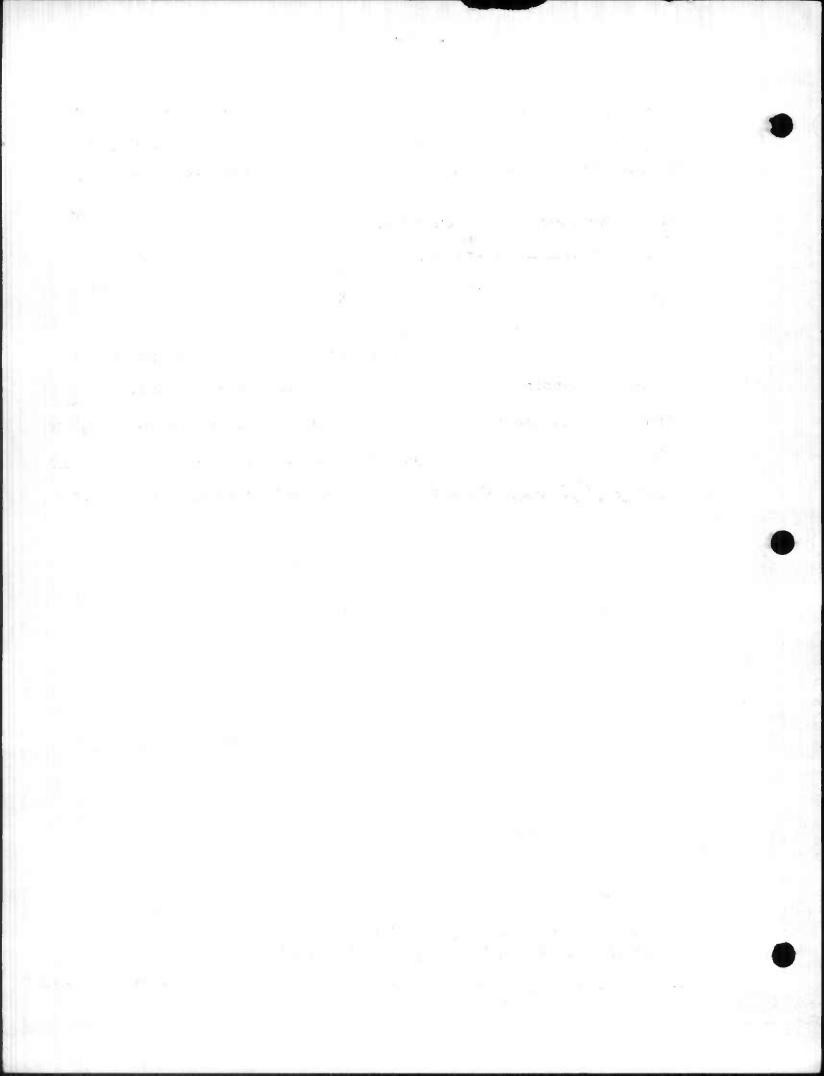
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. MD.

State Registrar

Medicai

GREGORIO M.

31. Date filed (Month, Day, Year)

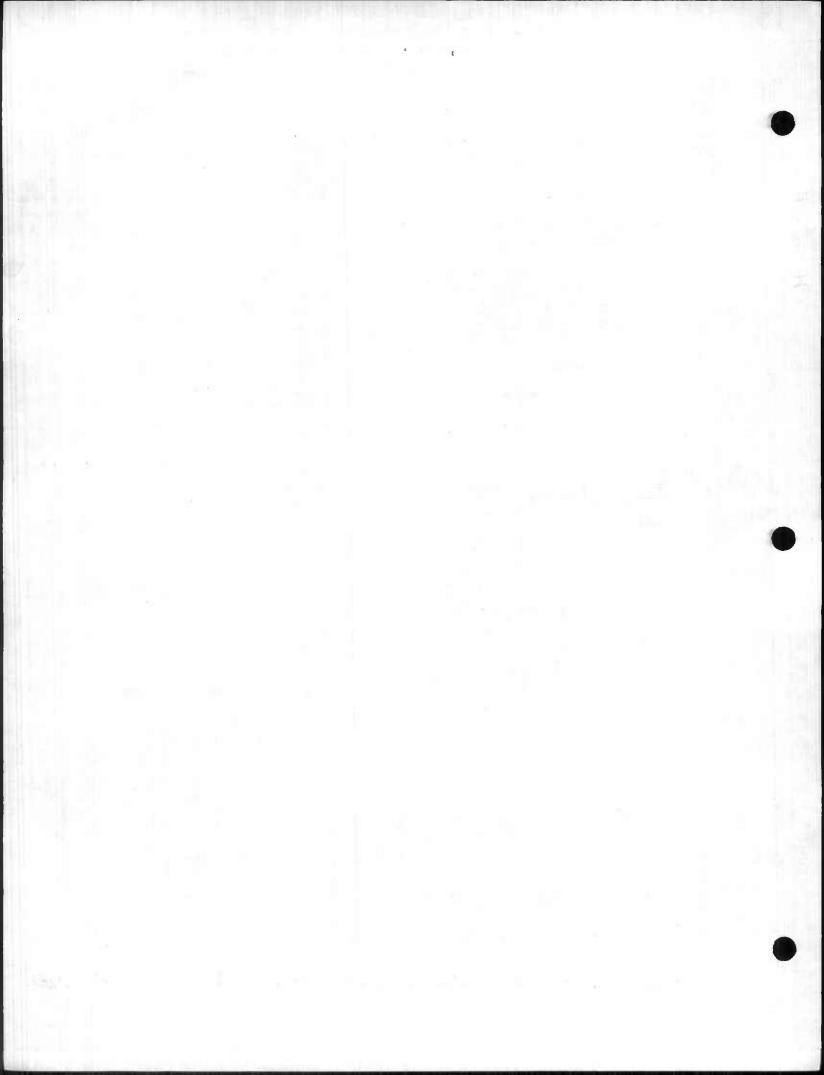


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Physician January 30, 2000 position of Death Dec. County of Death HARMAR CHARLES HILTZ 10 35 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO M Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months M 2DF Director 213-28-5264 Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Director 28a-f VA Accomack New Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 flerns 23a Funeral 7117 Tull Street 23415 USA 12. Was Decedent Evar in U.S. Armed Forces? 1 ¼ Yes 2 □ No 1948— If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Nevar Married 2 Married à 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1952 white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiana. other than Elementary/Secondery (0-12) College (1-4or 5+) 12 Police Officer Public Service 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Harmar Charles Hiltz Elsie Woodward 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: if Item 27 any Injury or other tr 7117 Tull St., New Church, VA 23415 Sharon Lynn Hiltz (wife) 20b. Place of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2/1/2000 Salisbury, Maryland Salisbury Crematory 21. Signature of Fufferal Service Licensee 22. Name and Addrass of Facility Holloway Melson Funeral Home P.A. mo1129 Dean 23a. Part1. Enter tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximately 10.3 Linden Ave., Pocomoke City, MD 21851

Approximately 10.3 Lin Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) 24 Shock Examiner Que to (or as a consequence of) tvelenous c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of): 8 esn igned by the atter Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o Yes 2 No 3 Probably 4 Unknown 0 renco Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeral Director: A Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2 ş 29b. Signature and 29c. License number 29d. Daye signed/(Month, Day, Year) 0 00 13222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. Regional Medical Centu LaytoN PPAINSULA 31. Data filed (Month, Day, 32. Registrar's Signature State 0 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Russell George Hansborough 27,2000 3:20 AM January /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15320 Pine Orchard Drive 3HSilver Spring
| H Under 24 Hrs. | A Date Montgomery If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1⊠M 2□ F Yrs. **Director** 75 22. 1924 Washington, D.C. 578-22-9142 Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15320 Pine Orchard Drive, 3H

Marital Stetus

12. Was Decedent Ever in U.S. Armed Forces? 20906 Funeral USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. filed within 72 hours after 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Business Manager Labor Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew John Hansborough Catherine A. Branan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Nieves (daughter) 10000 Durango Drive Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan.31 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 2000 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate shock, or heart feilure. List only one cause on each line. **Physician** ADENOCARCINOMA METASTATIC /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pur Due to (or as a consequence of): physician s the burial Box 68760. 8 Physician/Medical Due to (or as e consequence of): 88 950 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peed completion of cause of death? has page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Ne Hospital or Attanding Ph n 24 hours after death. Ne Funeral Director: After th 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only within 2 one) 29d. Date signed (Month, Day, Year) 10+1 DRIVE, SILVER SPRING 30. Name and address of person MI 31. Date filed (Month, Day, Year) 32. Registrer's Signature

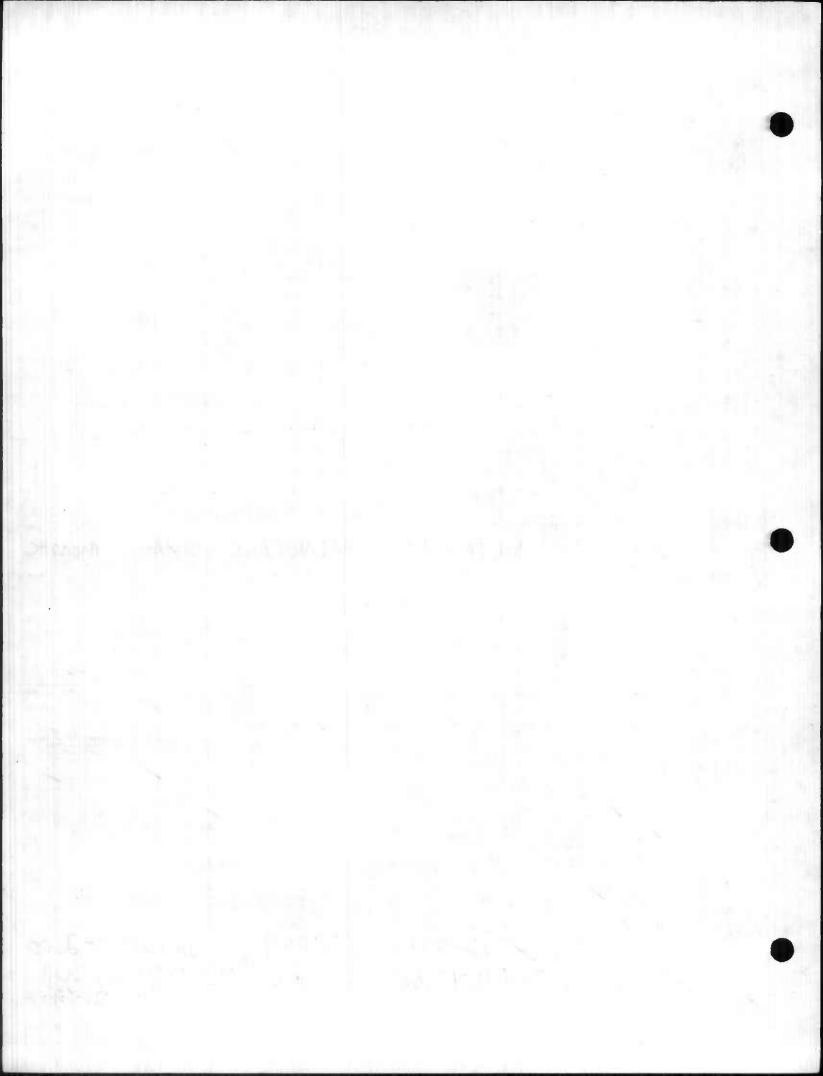
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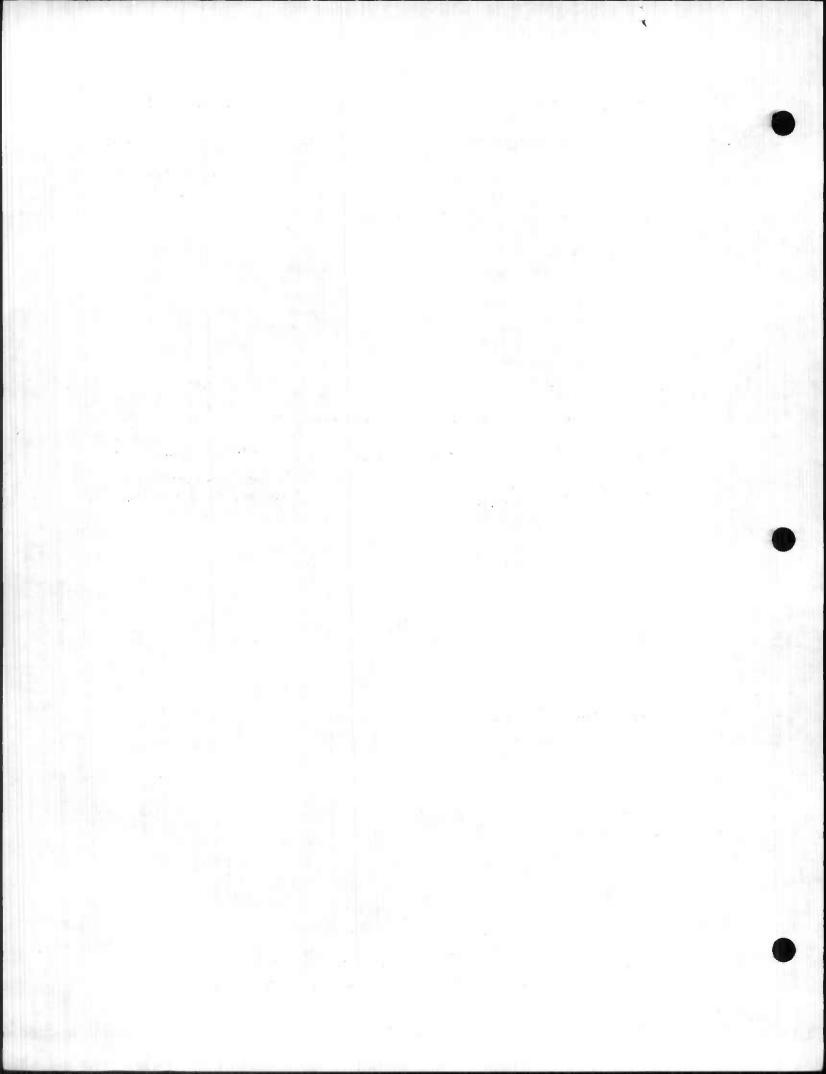
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| | State | of | Maryland | / Department | of | Health | and | Mental | Hygiene |
|--|-------|----|----------|--------------|----|--------|-----|--------|---------|
|--|-------|----|----------|--------------|----|--------|-----|--------|---------|

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death January **Physician** 31,2000 ETHEL P. HARVEY 5:50am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Dec. 23,1923 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2♥ F Months Deys Hours 224-26-7630 76 Virginia Director Usual Residence of Decedent 10a. Stale 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "nature!" or heme 23e or 28e 4 show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Montgomery Gaithersburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 20 Almaden Place United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yas, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 72 hours after 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: White ğ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygies Important: If hem 27 is marked other th any Injury or other re-12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be William Walter Pair Lou Carter Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Almaden Place Gaithersburg, Md. 20878 Mrs. Sandra Young (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Steta Feb. 6, 1 Burial 2 □ Cremetion 3 □ Removel from Stete Emporia Cemetery Emporia, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name end Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee witis 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications thet deuted the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aech line. Onset and Death **Physician** Immedieta Cause (Finel diseasa or condition rasulting in death) /Medical Sudded **Examiner** Examiner RIVE attending physician and for use as the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, diaselas Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? w voscular 1 Yea 2 No 3 Probably 4 Unknown MARIE Division of Vital Records. à 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical axaminer? Be 26 Place of Daath (Check only ona) 1 Yes 2 10 No OH 10 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 26a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? To the Hospital or Attending P.
within 24 hours after death.

To the Funeral Director: After if
y completely filled in by the funeral Pinatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 10 Januar uddress of person who completed cause of death (Item 23a) (Type, Print) /John Melnick M.D. 911 Russell Ave. Gaithersburg, Md. 20879 31. Date filed (Month, Day, Year) 32 Flegistrar's Signature State FEB 02 2000 Registra



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 29, 2000 2:55 pm Judith Ann Donaldson Hauser January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 12801 Jingle Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 3, 1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Deys Hours 51 Yrs. 214-52-2738 Director Usual Residence of Deceden the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MIL 12801 Jingle Lane 20906 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours efter 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 all Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) in and 2 should be fill Heelth and Mental H tem 27 is marked off Robert T. Donaldson, Sr. Josephine S. Sanford 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a
Department of Health an
Important: if item 27 is it
any injury or other treus
page. Josephine S. Donaldson/ Mother 4000 Elby Street, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20s. Method of Disposition NO Burial 2 ☐ Cremetion 3 ☐ Removel from State

Gate of Heaven Cemetery

22. Name and Address of Facility

Physician /Medical Examiner

the deeth certificate be executed

Box 68760.

P.O.

Records.

of Vital

Division Attending

Physician/Medical Examiner physician and the buriei-transit US0 08 þ Completed ebed 8 Medical Certification: To Director:

hes

After this certificate

deeth.

efter

To the Hospital or A within 24 hours effer To the Funerel Direct completely filled in by

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events resulting in death) Last

3 Suicide

29a. Certifier (Check only one)

4 Homicide

4 ☐ Donation 5 ☐ Other (Specify)

Uhren

21. Signature of Funeral Service License

Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. Was en autopsy performed? 26. Place of Death (Check only one)

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

25. Was case referred to medical Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of De 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1. SNatural 2 Accident

6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

NH24

2/3/00

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring,

Silver Spring,

MD 20901

Approximate Intervat Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

29b. Signature and title of contiline

29c. License number mo

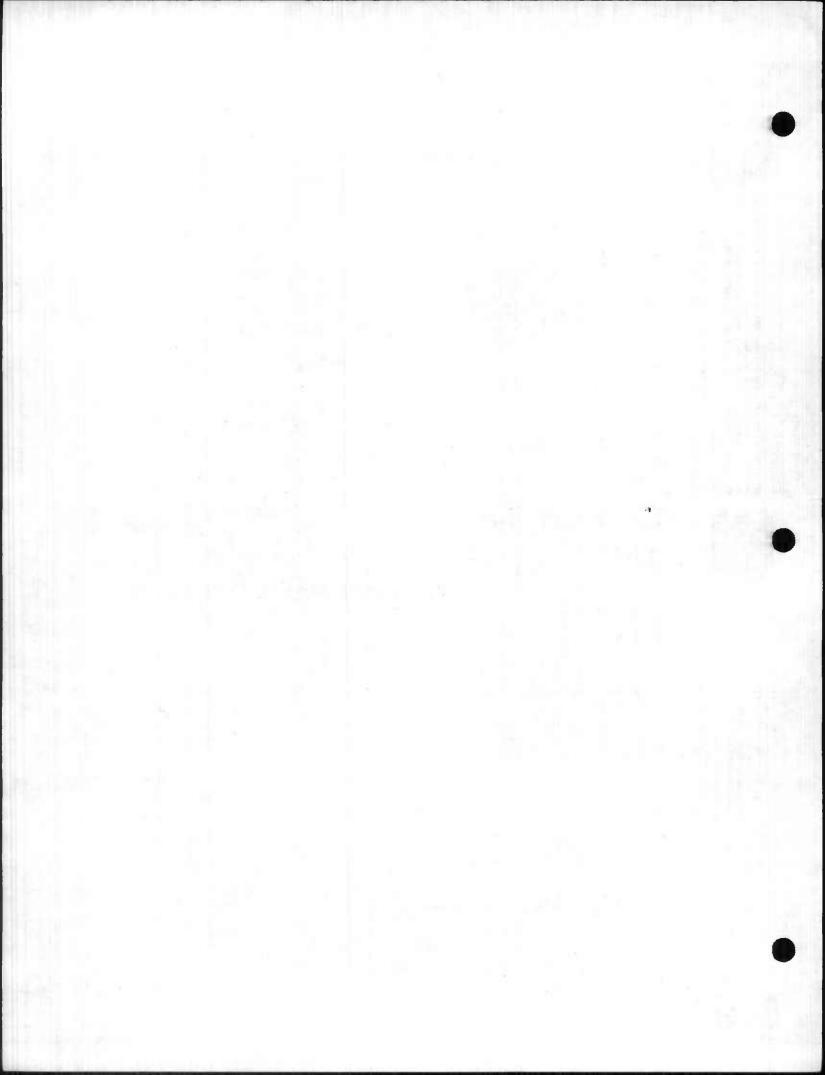
29d. Date signed (Month, Dey, Year) 0 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4820-10 da

32. Pegistrar's Signature

hysicians

State Registrar



Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0020 permit. Pages Department of Important: If it any injury or o

> **Physician** /Medicai **Examiner**

Physician

/Medical

10e. Stata

Directo

Funeral

þ

Completed

Be

Examiner

Funeral

Director

show

"naturel", or items 23s or odical Examiner must be:

the Medical

7 is marked other traumatic event,

Hem 2.

Health em 27

physician and s the burial-transit 88 980 signed by the aid be detached f should s certificate has t director, page 2 s the Hospital or Attending Physician: thin 24 hours after death.

The Funeral Director: After this certifical mpletely filled in by the funeral director, F

Be

2

Certification:

Medical

25. Was casa rafarred to madical axaminar?

5 Panding

investigation

30. Name end addrass of person who completed cause of deeth (Itam 23a) (Type, Print)

6 Could not be datarmined

1 Yas 2 No

27. Mennar of Death

1 Naturat

2 Accidant

3 Suicida

29a. Cartifiar

4 Homicide

(Check only one)

29b. Signatura and little of certifian

31. Date filad (Month, Day, Year)

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| To the | within 2 | To the | complet |
|--------|----------|--------|---------|
| | | 1 | > |

| 4 □ Donation 5 □ Othar (Specify) | St. Mary's Church Cemeter | 7 297 2000 | | | | |
|--|---|--|--|--|--|--|
| 21. Signature of Funeral-Service Livensee | Rapp Fund Address of Facility Stephen D. Lohrman 933 Gist Ave., Silv | remation Service n P.A. ver Spring, MD | es 20910 | | | |
| tmmediata Causa (Final | d the death. Do not enter the mode of dying, such as cardiac ine. Metastatic Cancer | or respiretory errest, | Approximete fintarval Batween Onsat and Death | | | |
| disease or condition resulting in death) a | Due to (or es a consequenca of): Dehydration | | 4 WEERS | | | |
| Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disass or Injury that initieted evants | b. Due to (or es a consequanca of): | | | | | |
| that initieted evants rasulting in death) Last | Dua to (or as a consequanca of): | | | | | |
| Part tt. Other significant conditions contributing to death b | out not resulting In the underlying causa givan in Part t. | 23b. Did tobacco use co | ntributa to the cause of death? | | | |
| | | 1 ☐ Yes 2Ñ No | 3 Probably 4 Unknow | | | |
| | | 24a. Was an eutopsy performed? | 24b. Ware autopsy findings available prior to comptation of causa of death? | | | |
| | | 1□Yas 2∏No | 1 ☐ Yas 2 € No | | | |

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

souls

29c. Licansa number

D00053528

2 No

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Piaca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

mo

Daphna Henkin M.D., 2309 Shorefield Rd., Wheaton, MD

32. Aegistrar's Signatura

28b. Time of

Injury

28a. Data of Injury (Month, Day Year)

37, 2000

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

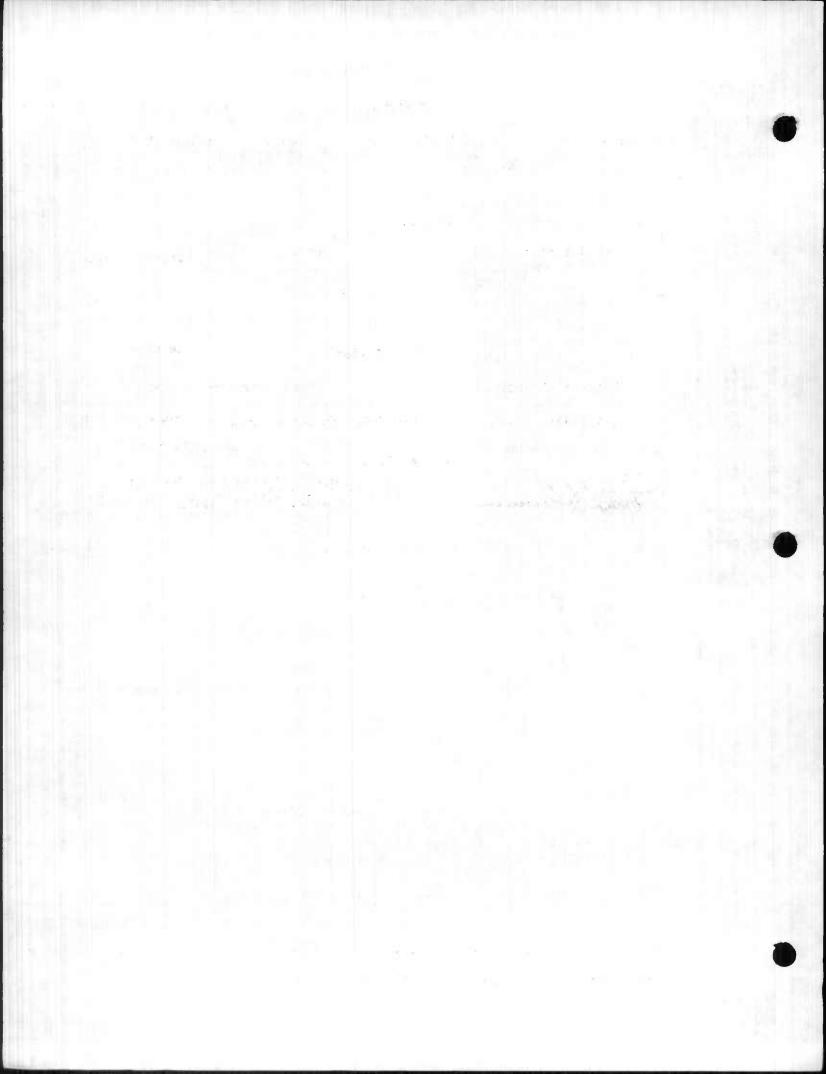
26. Placa of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidanca 8 Other (Specify)

20902

Registrar **DHMH 16 Rev 6/95**

State



04485 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Nema (First, Middle, Last) 3. Tima of Death Day Year **Physician** January 27,2000 4:40 AM /Medical James G. Hiltabidle, Jr. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Holy Cross Hospital Montgomery If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 113M 2□ F Yrs. 63 **Director** 579-46-7875 April 6, 1936 Illinois Usual Residence of Decedent r 28a-f show Inotified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yas 2 XNo Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Nems 23a Funeral 20901 110 Woodmoor Drive USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1∑ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Specify: White altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiera other then Elemantery/Secondary (0-12) College (1-4or 5+) General Trucking Truck Driver 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) . Pages 1 and 2 should be fit transford Pealth and Mental H fant: If Nem 27 is marked off dury or other traumatic even Be James G. Hiltabidle Violet Harries Pasmore 19e. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Nem 27 is any injury or other tra Violet Harries Hiltabidle 110 Woodmoor Drive Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Jan. 28 2000 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Arrhythmia disaase or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be assected Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medical Due to (or as a consequence of) US0 88 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ₺ Unknown signed I Mediastainal Addenopathy Completed by 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of causa of death? certificata has page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Yes 2 □ No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 SNetural s efter death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours e Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. completely (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F e fa 5 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Dey, Year) 1047 D 42578 Janaury 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

Gul Chablani,

31. Date filed (Month, Day, Year)

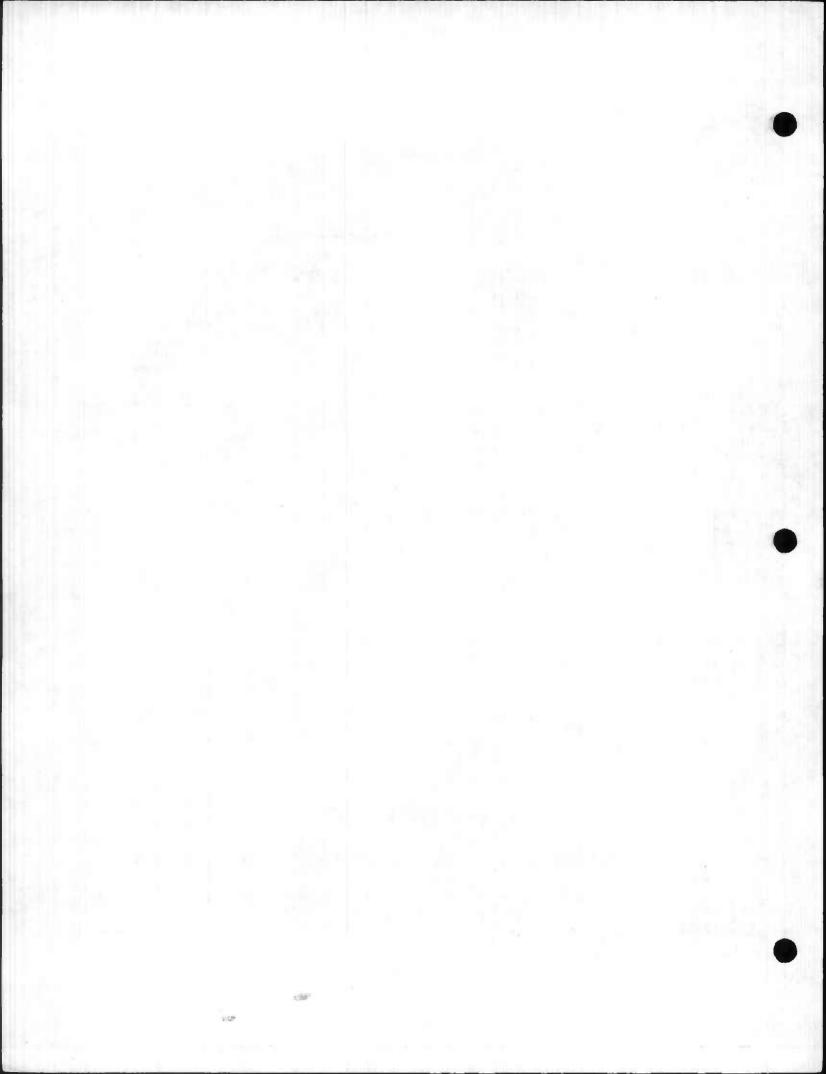
M.D.

JAN 31 2000

Rockville, MD

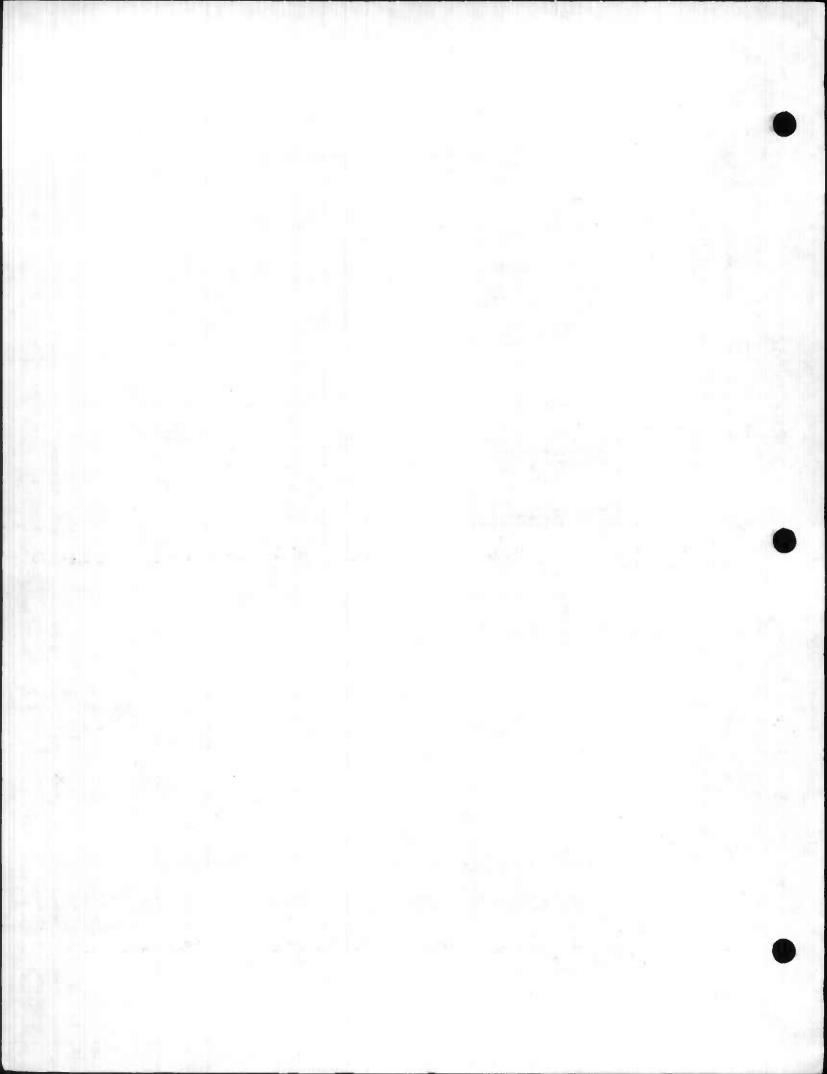
1119 Rockville Pike #401

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 04486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dale of Death **Physician** January
4b. City, Town, or Location of Death L 31, 2000 8:45 am /Medical Catherine Hoffmann 4a Facility Name (If not institution, give street and number) 4c, County of Death Examiner 14639 Bauer Dr. Apt 216 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 M 2 TF Yes 80 578-14-6260 Director Jan 15, 1920 Ohio Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location - how tOd. Inside City Limits r than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at 1 Yes 2 No Director Rockville Maryland Montgomery 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? deeth v 216 20853 USA 14639 Bauer Dr. Apt Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed withir Department of Heelih and Mentel Hyglene. Important: If Item 27 is marked other than any Injury or other traumetic avent, the Mentel Injury or other traumetic avent, the Mentel Elementary/Secondary (0-12) College (1-4or 5+) 8 Electronics Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Julia V. Munson 0 James R. Cruse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent A. Hoffmann/ Husband 14639 Bauer Dr. Apt 216, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery |2/4/00 Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Lice 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) NOW SMAL CEL /Medical Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): algned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen a Completed 90 1 Yes 20 No 250 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftert Certification: Attending Natural 5 Pending investigation or Attending a star deeth.

I Director: After din by the fur 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funerel Di completaly filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) MD FEBRUAR-035635 0005 10 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr., #327, Olney ,MD Joseph Kaplan, MD 20832 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State FEB 0 2 2000 oouts Registrar



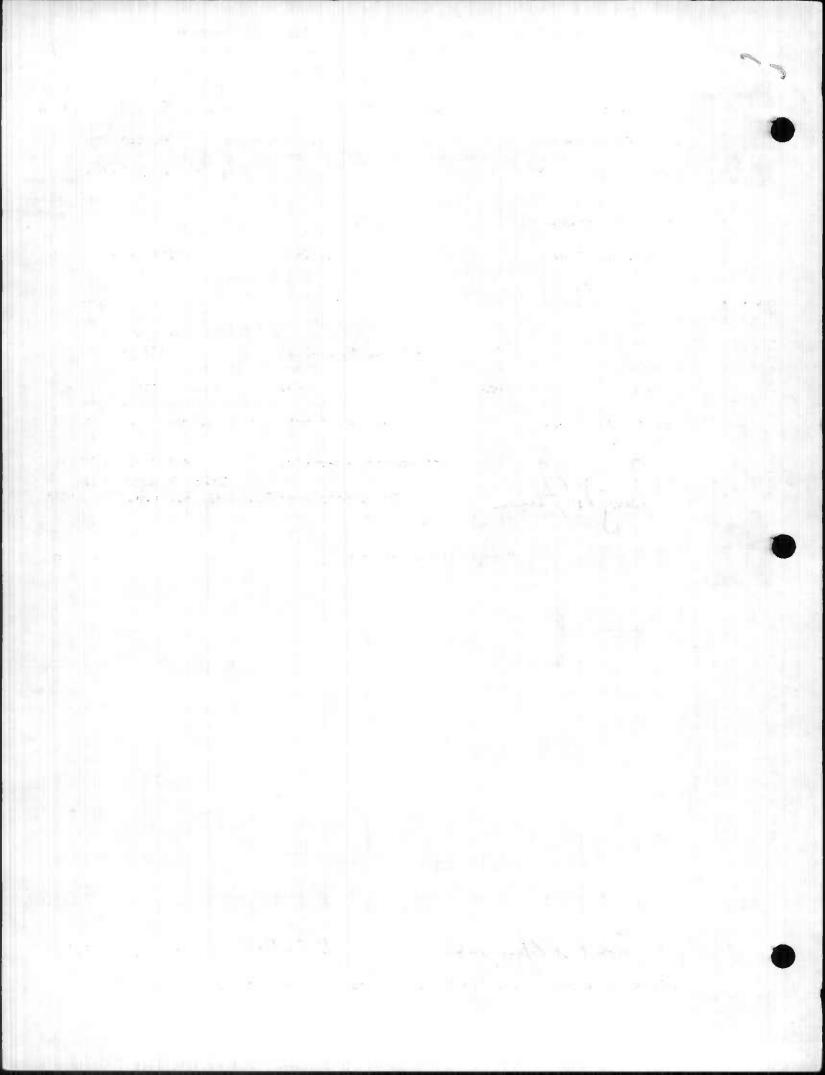
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04487 State of Maryland / Department of Health and Mental Hygiene Amend #5,2/1/2000, BMW, Monta, Co. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 30, 2000 Hong January 9:30 am Howard Minh /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery 10 Gardenia Court 5. Social Security Number 5286 8. Date of Birth (Month, Day, Year) Sept 25, 1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1₩ 2□ F Yrs. 1953 Vietnam 586-28-5826 46 **Director** Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Menyland Department of Health end Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examinar mass in months. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 United States 10 Gardenia Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. À 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Heating and College (1-4or 5+) Elementary/Secondary (0-12) Air Conditioning Manager/Specialist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cham Tran Chi Hong 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Hong, 10 Gardenia Court, MD 20879 wife Gaithersburg, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/3/2000 Alexandria, Virginia 4 Doration 5 Other (Specify Metropolitan Crematory of Fuperal Service 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart billure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel diseese or condition resulting In death) Nasopharyngeal Cancer 2 years Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) 80 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 2 ♥ No 1 ☐ Yes 2 ☐ No certificete or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? After 1 Natural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined n 24 hours after der Ne Funeral Director pletely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ሼ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. edical To the Hosp within 24 hos To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52810 January 31, 2000 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 1 2000

32. Rugistrar's Signature

Robert C. Shepard, M.D., 10810 Connecticut Avenue, Kensington, MD

G. Sparks



Physician /Medical Examiner

Depertment of Important: If any Injury or once.

Physician

/Medical

Examiner

MD

Directo

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mentel Hygiene.

Int: If them 27 is marked other than "natural", or that my or other traumetic event, the Medical Examination.

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with

death

Examiner Physician/Medical þ Completed

slcian and buriel-trensit physician a USB as signed by the ald page 2 s certificate director, this funerel In by

Be Lo Certification:

deeth certificate be executed Hospital or Attending Physician: after death. To the Hospital or within 24 hours aft To the Funeral Di completely filled in

P.O.

Records,

Division of Vital

Medical

State Registrar

31. Dete filed (Month, Day, Year) FEB 04 2000

29b. Signetura end title of cartifiar

2 Accident

4 Homloide

3 Sulcide

29a. Certifier

investigation

6 Could not be determined

CHRISTOPHER FLEMING, M. D. 32. Registrer's Signeture

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

4014 MOUNTVILLE ROAD, JEFFERSON, MARYLAND 21755

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner stated.

29c. License number

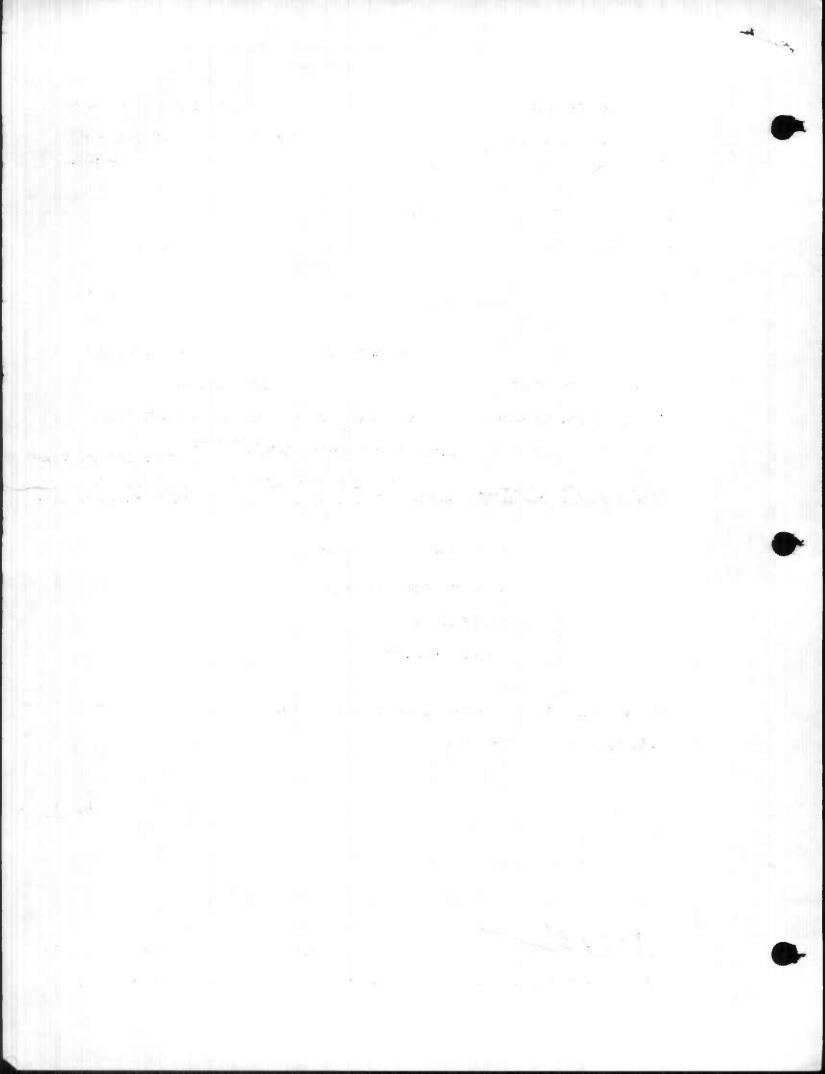
D37178

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month. Dev. Year)

JANUARY 26, 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3 Time of Death 1. Decedent's Neme (First Middle Last) Month Robert 25, Horswood January 2000 9:40A. 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Doctors Community Hospital Lanham Prince George's If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Deys 1 X M 2 □ F 197-24-3791 72 Yrs. June 20, 1927 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Xes 2 No Prince George's Maryland Greenbelt. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 5997 Springhill Drive, #103 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus XXYes 2 No If Yes, Give Year or Detes: 1944-1946 1 Never Married 2 Married 1 Yes ZXNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Microbiologist N.I.H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) George J. Horswood Helen. Monaghan 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mary Lou Horswood (wife) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Maryland Veterans Cemetery 2/1/2000 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. SOURWORT 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the diseese, or complicatures that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one charge on each line. Approximete Interval Between Onset end Deeth Several Immediate Cause (Final disease or condition resulting in death) Lardiofulmonare Due to (or as e consequence ot): minutes ronar Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of) Due to (or as a consequence of):

Physician /Medicai Examiner

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Department of Important: If its any injury or o

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

"natural", or items 23s or solical Examiner must be 7

Pages 1 and 2 should be filed within 72 hours after deeth vent of Health and Mentel Hygiene.
Intent of Health and Mentel Hygiene.
Int: If item 27 Is marked other than "natural; or items 23s my or other traumatic svent, are traumatic svent, are traumatic svent, are traumatics.

altimore, Maryland 21215-0020

with the Marylend r 28a-f show

> Physician/Medicai Examiner nding physician end use as the burial-transit that initiated events resulting in death) Lest use as t signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred 281. Location (Street end Number or Rural Route Number, City or Town, State)

þ Completed Be 2 Certification:

Medicai

page 2 s 385

certificate

After this

death.

within 24 hours

funeral

à Direc

filled in

To the Fune completely fi

28

Attending Physician:

6

27. Manner of Death 1 Naturel 2 ☐ Accident 3 ☐ Sulcide 4 Homicide

25. Was case referred to medicat examiner?

1 Yes 2 No 5 Pending Investigation 6 Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signature appoints of certifier

D46093

29d. Date signed (Month, Dey, Year)

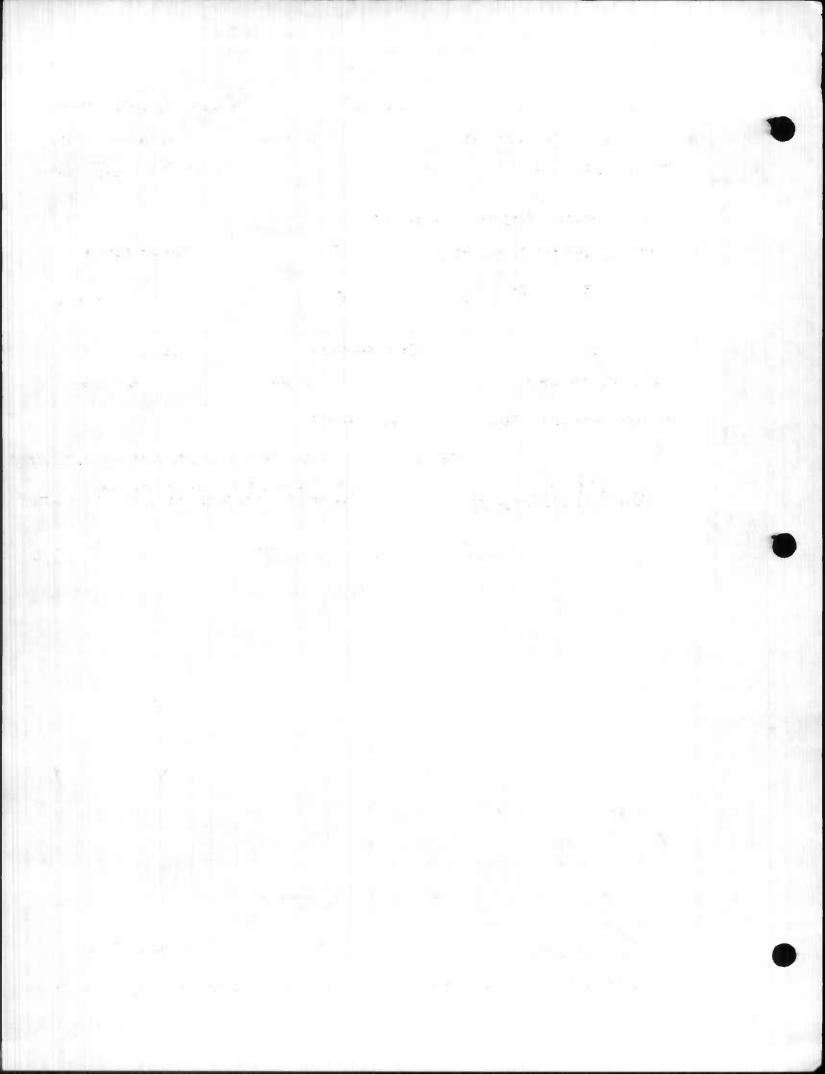
January 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radman Mostaghim, M.D. 7305 Hanover Parkway, Suite A Greenbelt, Maryland 20770

State Registrar 31. Date filed (Month, Dey, Year)
JAN 31 2000

32. Begistrer's Signeture



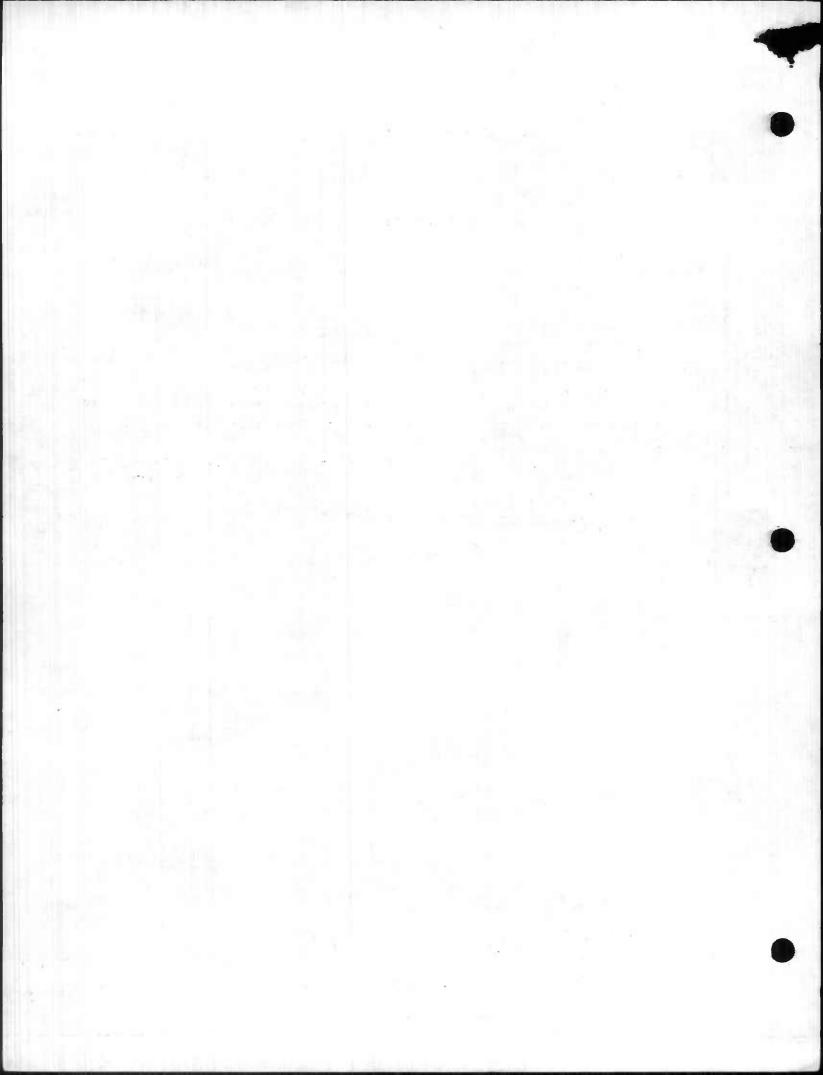
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Amend #19a,2/3/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:10 PM William Joseph Hunt Sansar 30 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F 87 Director 218-03-4380 Sept. 26, 1912 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita r than "natural", or items 23s or 28s-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 1111 Fallsmead Way 20854 Funeral United States 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. Pages 1 and 2 should be lifed within 72 hours after and of Health and Mental Hygiene.
If item 27 is marked other than "natural, or the ury or other treumatic event, the Nexus 1 Yes 22 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☑ Widowed 4 ☐ Divarced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Gas Station Attendant Gas Station 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter James Hunt Fickeys Mary Ann 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Hunt (Son) 1111 Fallsmead Way, Rockville, MD 20854 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 12 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Joseph's Cemetery 2/5/00 Fullerton, MD 21. Signeture of Furieral Service bicenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 23a. Part1. Enjer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel Preumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Onknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law 28 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending 1 Natural 5 Panding To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29e. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certific 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #202 Rocherlle M 20852 15201 Shedy Grave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

0 3 2000

FEB



Piease Type or Print in Biack Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04491 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Dey Month Year Physician MARGUERITE 3:00 PM 28 200 500 Januar /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Lorien Nursing Home Columbia If Under 24 Hrs. Howard If Under 1 Yaer 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 □ M 2 🖾 F Months Director 103 212-74-3677 Oct.31,1896 Washington, D.C. Usual Residence of Decedent Manyland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Howard Columbia the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5827 Wyndham Circle death Funeral #102 21044 USA 14. Rece - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiewe. Important if Itam 27 is marked other than "natural", or haven filtery or other traument. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be James Hawkins May Whittier 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Frederick Hutchison (son) 5827 Wyndham Circle #102 Columbia, Maryland 21044 20b. Piace of Disposition (Name of cemetery, crematory or other place) Data 20e. Method of Disposition 20c. Location - City or Town, Stete 12 Buriei 2 ☐ Cremetion 3 ☐ Ramovel from Stete Feb. 2 4 ☐ Donetion 5 ☐ Othar (Specify) Cedar Hill Cemetery 2000 Suitland, Maryland 21. Signature of Funeral Service Licenses, 1 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Part 1. Enter the dispose, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each lina. 23a Parti Approximata Interval Between Onset and Death **Physician** Kementia /Medical Immediate Cause (Finel disease or condition resulting in deeth) Lyer Examiner Due to (or es a consequence of) Examiner attending physician and for use as the bunal-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. by 8 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an sutopsy performed? Completed peen has page 2 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner? 26. Placa of Death (Check only ona) Be Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this all or Atta. Jurs after death. real Director: After thi by the funer funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours at To the Funeral DI tel Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical To the Fune completely fi (Check only one)

Registrar

DHMH 16 Rev 6/95

State

29b. Signature and title of gently

Gary Prede, MD 31. Dete filed (Month, Day, Year)

JAN 31

30. Nama and admass of person who complated causa of death (Item 23a) (Type, Print)

11055 Little Patuxen Dr., Columbia, MD

32. Registrer's Signeture

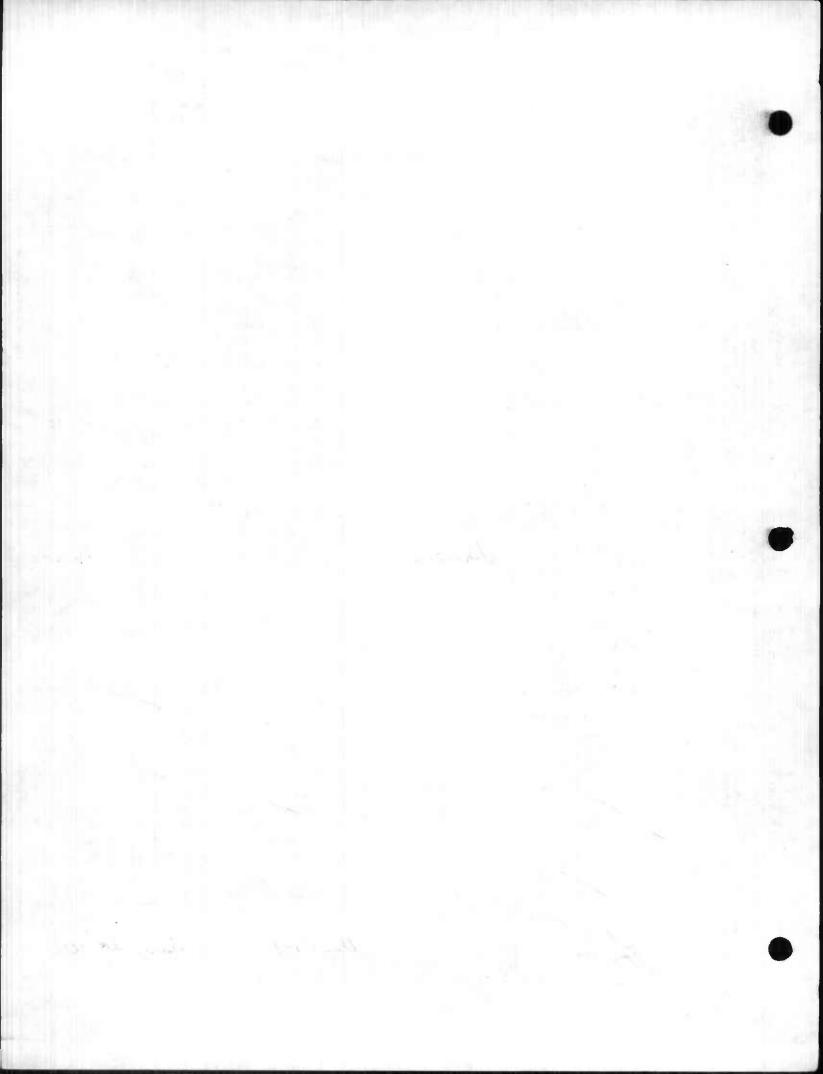
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29c. License number

oaks

29d. Date signed (Month, Day, Year)

Varian,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 11 1 1 9 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** -Month Dey Yeer 12:15 AM FEBRUARY 1, 2000 JOAN NILA HAERTIG /Medical 4e. Fecllity Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 / 24 / 1 9 3 8 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** Months 1□ M 20 F MARYLAND 61 Yrs. 212-36-8248 Director Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD. CARROLL WESTMINSTER 10e. Street end Number 10f. Zip Code 10g. Citizen of Whel Country? 5 "natural", or items 23a 433 SPALDING COURT 21158 USA. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 Never Married Merried 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th end Mentel Hygiene.
7 Is marked other than "r Elementary/Secondery (0-12) College (1-4or 5+) 10 DELI CLERK FOOD 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) STANLEY STEVE KIRK HAZEL MARIE SMITH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Important: if item 27 is any injury or other any ROBERT L. HAERTIG-HUSBAND 433 SPALDING CT., WESTMINSTER, MD. 21158 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremellon 3 ☐ Removel from State METRO CREMATORY 2/1/00 BALTIMORE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility FLETCHER FUNERAL HOME 21. Signeture of Funerel Servica Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** LUNG CARCINOMA /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): that the death certificate be axecuted sician and burief-trans Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thei Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical the Due to (or es a consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed t should be det by Be Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 No this certificata 25. Wes case referred to medical exeminer? 26. Piace of Deeth (Check only one) Hospitel: 1 population 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 70 1 ☐ Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Neturel s after death.
I Director: Aft
ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours al To the Funeral D completely filled 29a. Ceptrier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, deta and piece, end due to the cause(s) end menner stated. edicai /Check anh 29b. Signature and title of pertilier 29c. License number 29d. Dete signed (Month, Dey, Year) 51245 FEBRUARY 1, 2000

State Registrar

31. Dete filed (Month, Dey, Year) FEB 0 1 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 200 Memic Pine DR. Westminster SASID SHARIF CARROLL COUNTY GENERAL 145 PITAL -ME 32. Registrer's Signeture

D. Sports

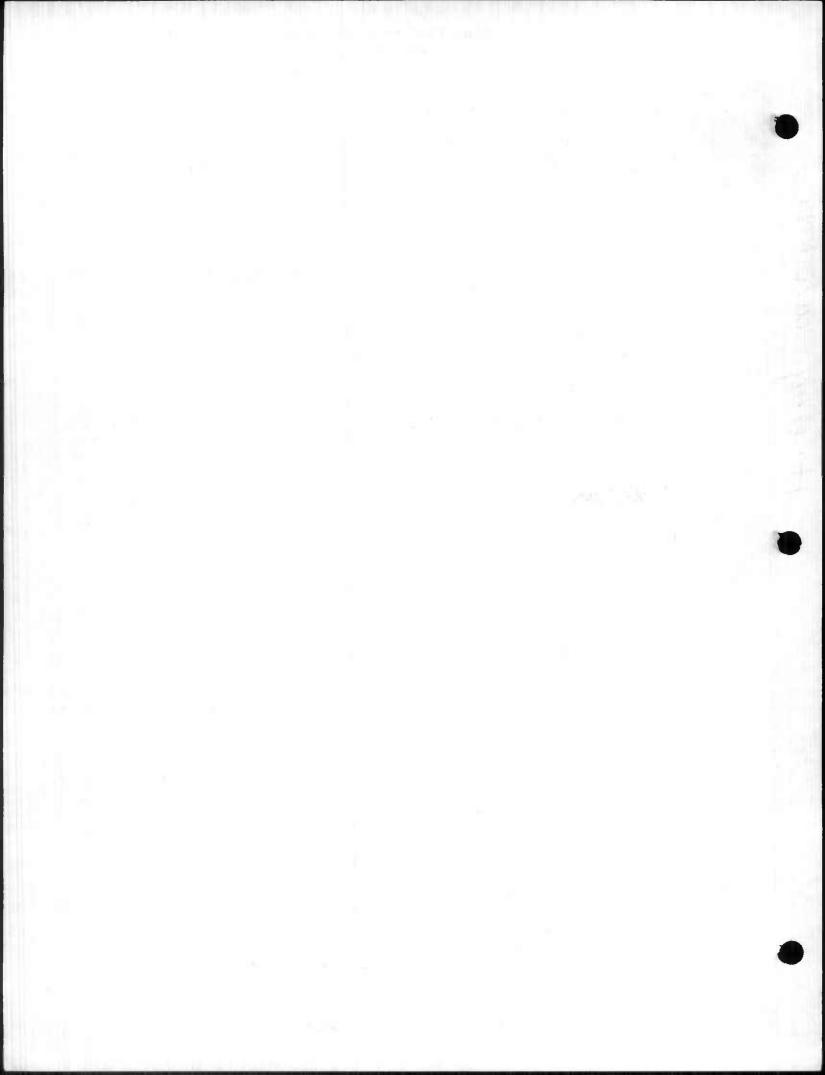
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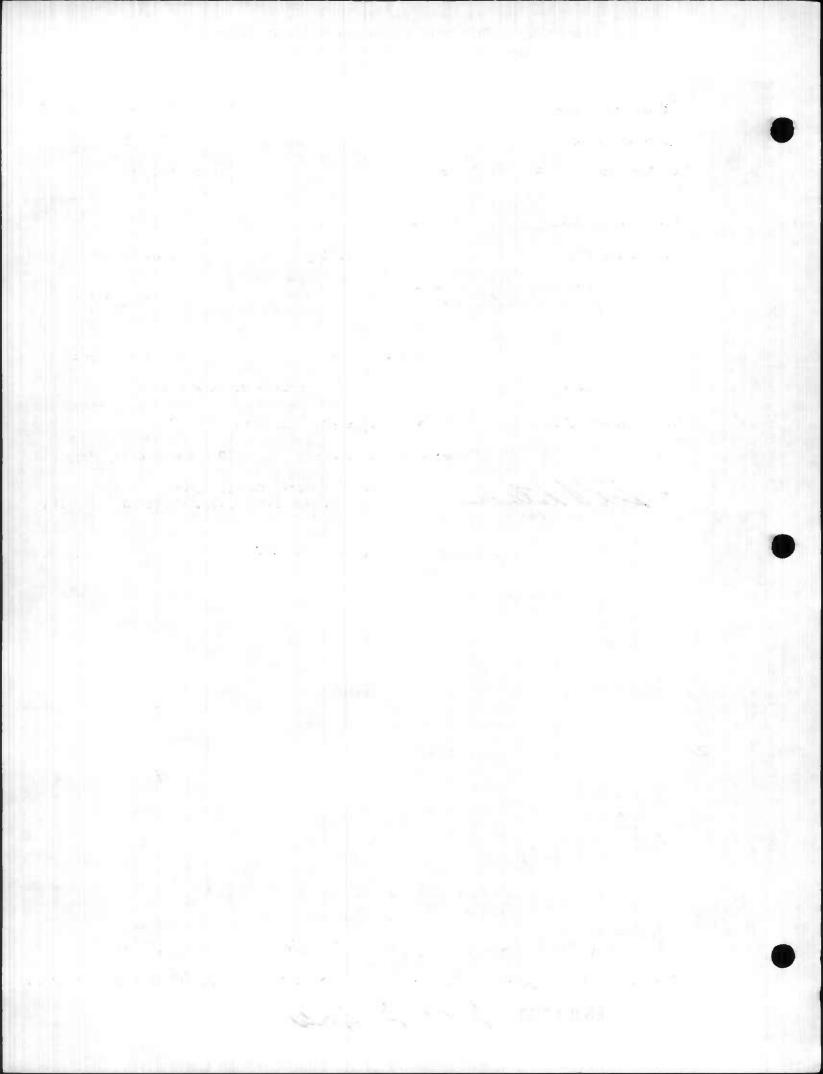
of Vital

Division



State of Maryland / Department of Health and Mental Hygiene 0 011593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year Month **Physician** 6:45 PM 30 2000 Floyd B. Hulver Jan /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 6419 Ridge Rd. Mount Airy Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours Min. 1₩ M 2□ F 212-38-4725 59 Yrs. Sept. 8, 1940 Virginia **Director** Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be death with 6419 Ridge Rd. 21771 United States Funeral 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 1962— If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 282Merried Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dales: 1965 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Senior Operator Colonial Pipeline other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H Floyd I. Hulver Sallie M. Streaker 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Hulver (Wife) 6419 Ridge Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 t⊠ Burlat 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or other Pine Grove Cemetery 2/4/2000 Mount Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice License 22. Neme and Address of Facility Burrier-Queen Funeral Home elle 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final METASTARC COLON CANCER 3 YEARS disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner requires that the death certificata be executed physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): USB 85 been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evelleble prior to 24a. Was en autopsy Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending after death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29e. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as steted. edicai within 24 ho To the Functional (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and little of certifier 29c. License number tranco K. (salvis III om D31660 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) HOMAS K. GALVW III MS 295 STOWER AVE WESTMINSTER MO 21157 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 0 1 2000 Registrar Dener

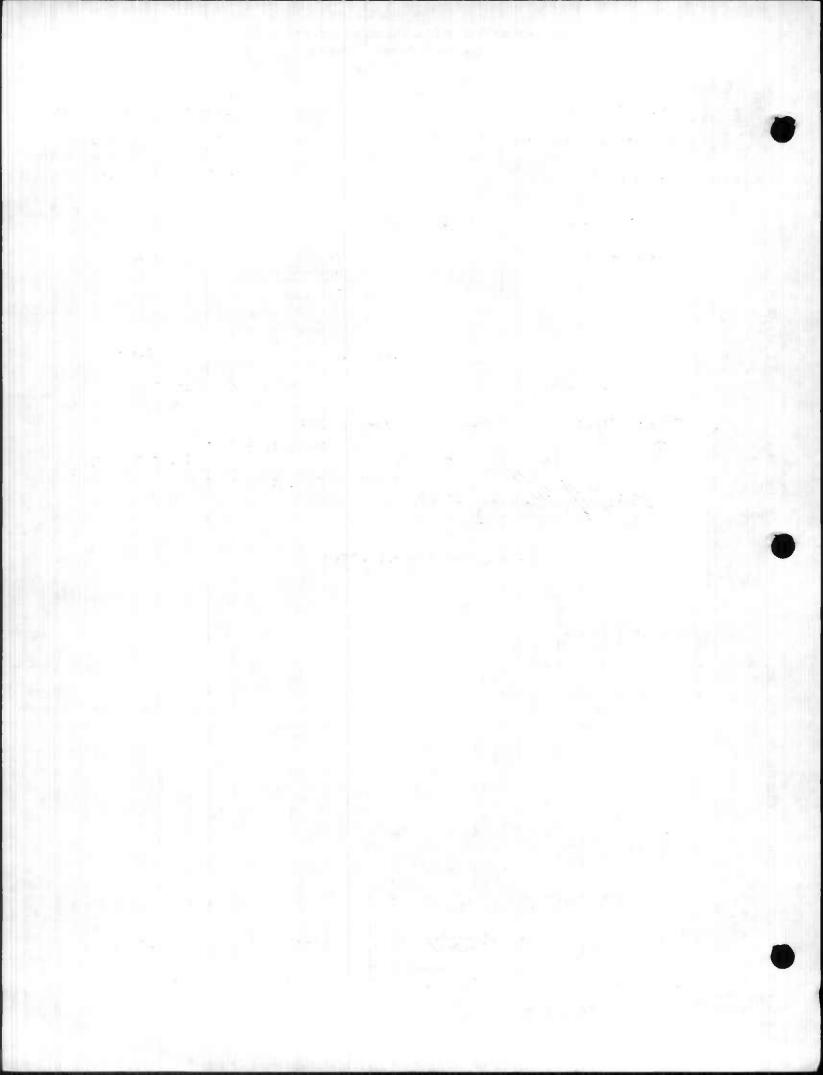
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or itams 23s or 23s-f above any injury or other traumatic evant, the Medical Examines." In Medical Examines 23s or 23s-f above any injury or other traumatic evant, the Medical Examines may injury or other traumatic evant, the Medical Examines and injury or other traumatic evant, the Medical Examines 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s-f above 23s or 23s | Suel Residence of Dacedent | a street and number) I C C ex | 18a +) 19a 20b. Place of cemete | Yrs. Month Yrs. Month In or Location In Head 106. 2 13. Was Dec If Yes, signification of Ville Book No. 7 Homemak Mailing Address Same of Disposition (Aug., crematory of Property, crematory of Property, crematory of Property, crematory of Property Inc., p. 100 months of Proper | Zip Code 2064 cedent of the pecify Cub 2 DANo sual Occup work done fuse retire (CET | 40 Indian If Under 24 Hrs. Hours Min. AO Alispanic Origin? (S. an, Mexican, Puert Specify: Deation during most of word) 18. Mother's Nar Nellie | Head 8. Date of Bir (Month, Da June 25) pecify Yes or No o Rican, etc.) | th y, year) 10g. Citizen of V U.S.A 14. Rac Blac Specify 16b. Kind of Be Her Ho Maiden Suman Hamilton | of Death Char 9. Birthpr Coun Wash: What Coun e - Amarick, White, Whit usiness/inc | lace (State or Fore try) Ington D. Od. Inside City Lim 1 2 Yes 2 1 the try? can Indian, etc. | |
|--|--|--|--|--|--|--|---|---|--|--|--|
| Medical Important: If item 27 is marked other than "natural; or items 23e or 28e-f above any injury or other traumatic evant, the Medical Evantuar must be northed at any injury or other traumatic evant, the Medical Evantuar must be northed at any injury or other traumatic evant, the Medical Evantuar must be northed any injury or other traumatic evant, the Medical Evantuar in the mortal process. To Be Completed by Funeral Director | a Facility Name (If not institution, given 11 Kenwood Place). Social Security Number 6. S 212-66-3110 1 Sual Residence of Dacedent 10a. State 10b. County Maryland Charles 10c. Street and Number 11 Kenwood Place 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highast grass Elementary/Secondary (0-12) 8 7. Father's Name (First, Middle, Last) Carroll B. Wedding 19c. Informant's Name/Relationship (19c) 19c. Informant's Name/Relationship (1 | 12. Was Decedant F Armed Forces? 1 — Yes 245 M Yas, Giva Yaar or Dates: Jucation da completed College (1-4or 5) Type, Print Husbar Husbar College (1-4or 5) | 10c. City, Tow India Ever in U.S. io 18a +) 19t 20b. Place c cemete | Yrs. Month Yrs. Month In or Location In Head 106. 2 13. Was Dec If Yes, signification of Ville Book No. 7 Homemak Mailing Address Same of Disposition (Aug., crematory of Property, crematory of Property, crematory of Property, crematory of Property Inc., p. 100 months of Proper | Zip Code 2064 cedent of the pecify Cub 2 DANo sual Occup work done fuse retire (CET | 40 Indian If Under 24 Hrs. Hours Min. AO Alispanic Origin? (S. an, Mexican, Puert Specify: Deation during most of word) 18. Mother's Nar Nellie | Februa Location of Deati Head 8. Date of Bir (Month, Da June 25 pecity Yes or No o Rican, etc.) king me (First, Middle Marie I | th year) 10g. Citizen of V U.S.A 14. Rac Blac Specify 16b. Kind of Bu Her Ho | of Death Char 9. Birthp Coun Wash 1 What Coun • - Amarick, White, Whit usiness/income | les lace (State or Fore tity) Od. Inside City Lim 1 Yes 2 1 stry? can Indian, etc. | |
| Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic evant, the Medical Evantuar must be notified at any injury or other traumatic evant, the Medical Evantuar must be notified at any injury or other traumatic evant, the Medical Evantuar must be notified any injury or other traumatic evant, the Medical Evantuary or other traumatic evant. To Be Completed by Funeral Director | 11 Kenwood Pla Social Security Number 212-66-3110 Suel Residence of Dacedent Oa. State 10b. County Maryland Charles Oe. Street and Number 11 Kenwood Place 1. Marital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highast gras Elementary/Secondary (0-12) 8 7. Father's Name (First, Middle, Last) Carroll B. Weddin 19e. Informant's Name/Relationship (1) Oale R. Hayes Oa. Mathod of Disposition 19e Purial 2 Cremation 3 Date of Disposition 19e Purial 2 Cremation 3 Date of Disposition 19e Purial 2 Cremation 3 Date of Disposition 19e Purial 2 Cremation 3 Date of Disposition 19e Purial 2 Cremation 3 Date of Disposition 19e Purial 2 Cremation 3 Date of Disposition 5 Dother (Specify 2) 11. Signature of Funeral Service Learn | 12. Was Decedant F Armed Forces? 1 — Yes 245 M Yas, Giva Yaar or Dates: Jucation da completed College (1-4or 5) Type, Print Husbar Husbar College (1-4or 5) | 10c. City, Tow India Ever in U.S. io 18a +) 19t 20b. Place c cemete | Yrs. Month Yrs. Month In or Location In Head 106. 2 13. Was Dec If Yes, signification of Ville Book No. 7 Homemak Mailing Address Same of Disposition (Aug., crematory of Property, crematory of Property, crematory of Property, crematory of Property Inc., p. 100 months of Proper | Zip Code 2064 cedent of the pecify Cub 2 DANo sual Occup work done fuse retire (CET | Indian If Under 24 Hrs. Hours Min. Hours Min. Hours Min. AO Hispanic Origin? (S an, Mexican, Puert Specify: Deation during most of word 18. Mother's Nar Nellie and Number or Re | Head 8. Date of Bir (Month, Da June 25) pecify Yes or No o Rican, etc.) | th, Year) 10g. Citizen of V U.S.A 14. Rac Blac Specify 16b. Kind of Bu Her Ho | of Death Char 9. Birthpr Coun Wash: What Coun e - Amarick, White, Whit usiness/inc | les lace (State or Fore tity) Od. Inside City Lim 1 Yes 2 1 stry? can Indian, etc. | |
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| | mache | 4//- | | Rest Ce | mete | -4 | | 20c. Location - LaPlata | | | |
| | M00668 4270 Hawthorne Rd., Indian Head, Md. | | | | | | | | | | |
| 2 | 23e. Pert1. Enter the displace, or comp shock, or haar faller. List only | plications thet sauted | | | | | | | rid. Z | 20640 Approximate Interval Between | |
| ysician : | shock, or haad fallene. List only | one cause on each lin | 10. | | | | | | i | Onset and Death | |
| Medical In | mmediate Ceuse (Final | Small | Coll I | una C | 2220 | 20 | | | | 4 | |
| aminer | disaase or condition esulting in death) | α. | | | | L | | | | 148 | |
| je je | Oue to (or as a consequence of): | | | | | | | | | | |
| is the bunal-transit edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | |
| O 40 | Cause (Disease of Injury that Initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| r use | d. | | | | | | | | | | |
| Sick Sick | art II. Other significant conditions co | 23b. Did | 23b. Did tobacco use contribute to the cause of death? | | | | | | | | |
| igned by the attendir be detached for use by Physician/N | | | | | | | Probably 4 | | | bably 4 Unknown | |
| 2 should | | | | | | | 24e. Wes | 24e. Wes an autopsy performed? | | ere autopsy finding allable prior to impletion of cause death? | |
| Page Co. | | | | | | | 10 | Yes 25 No | 1[| Yes 2□ No | |
| certificate rector, pag | 5. Was case referred to medical axaminer? | | | | | | eth (Check only | one) | | | |
| this cal dire | 1 Yes XXNo | Hospital: 1 Inpatie | | utpatient 3□ | DUA | | 1 | denca 8 □Oth | | (y) | |
| the transfer to | 7. Manner of Death XX Neturel 5 Pending | 28a. Dete of fnjur (Month, Day | | Time of Injury | 28c. fnju Wo | nryat nrk?]Yes 2 □ No | 28d. Describe | how Injury occur | red | | |
| within 24 hours effect death. To the Funeral Director: Affer this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com | 2 ☐ Accident Investigation | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Placa of fniury - At home, farm, street, fit | | | | | | n (Streat and Number or Rural Routa Number, Town, State) | | | |
| Pletely filled | 29a. Certifier X Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best onliner: On the basis of and manner sta | examinetion ar | e, death occurrend/or investigeti | ed at the ti | me, date and place opinion, deeth occu | , and due to the urred at the time, | cause(s) and modate and pleca, | anner as s and due to | itated. the cause(s) | |
| otton September 29 | 9b. Signature and title of certifier | M. Ma | Ilm | | 29c. Licen | se number 8352 | | 29d. Date signe Februa | | Day, Year) 2, 2000 | |
| L L | 0. Name and eddress of person who | | | | 3 т | 2 Dla±- | MD | 20646 | | | |
| 24 | Krishan Mathur 1. Dete filed (Month, Day, Year) | | y's Signeture | JX 1/U. | ىل , د | a Plata | , MD . | 20646 | | | |
| State State Registrar | FEB 0 4 | | s signeture | 4 | 1 | els | | | | | |



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| Grover | Cleveland | Hugnes | Jr. | State of Maryland | Departm |

nent of Health and Mental Hygiene

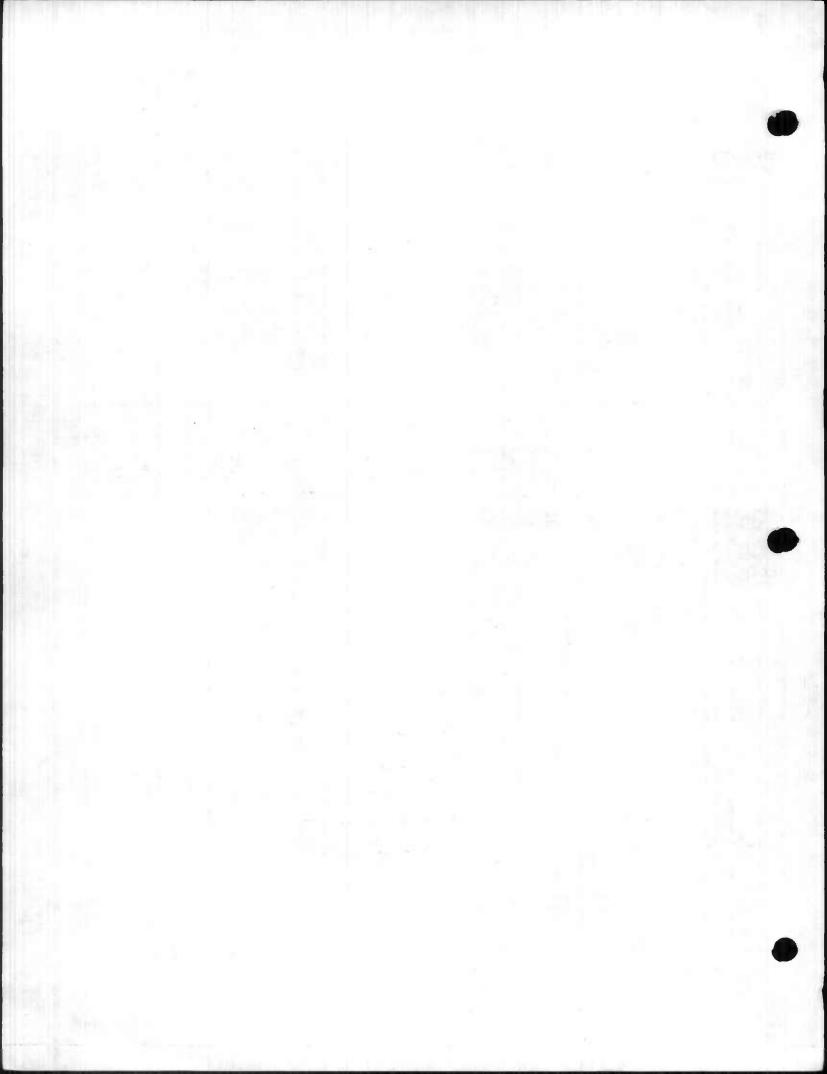
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| J | | 11 | 11 | 12 | V | hon |
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| | | | C | ertificate | e of i | Death | F | Reg. No. | 2 04439 | | |
|--|--|---|--------------------|-------------------|------------------|--|---|--|--|--|--|
| Physician | 1. Decedent's Neme (First, Middle, Li | ast) | | 100 | | | 2. Dete of Dee Month | Day Ye | 3. Time of Death | | |
| /Medical | Grover Cleve | | s, J | r. | | | Januar | y 19 20 | 000 18:07 P.M. | | |
| Examiner | 4a Facility Name (If not institution, gi | | | - D3 | 4 | b. City, Town, or Lo | | , | | | |
| | | North Franklin | | | 1 Vans | Thurmon | | Frede | | | |
| * Funeral Director | 212-74-2732 | Sex 10XM 2□ F 7. Age (In yrs. 42 | last birthd Yrs | Months | | Hours Min. | 8. Date of Birt (Month, Da) Dec. 3(| Year) 9. 1957] | Birthplace (Stete or Foreign Country) Pennsylvania | | |
| 2 E- | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town o | Location | | | | | 10d. Inside City Limits | | |
| on the Maylar or 28e's show be notified at | Maryland Freder | ick T | hurmo | nt | | | ¥ Yas 2□ | | | | |
| 10 S S S S S S S S S S S S S S S S S S S | 10e. Street and Number | | | 10f. Zip | | | | et Country? | | | |
| Z1Z15-00Z0 d within 72 hours after death with piere. r then 'naturel', or here 23e or the Medical Examiner must be sompleted by Funeral Dir | 3 Frederick Road | | | | | 88 | | United S | | | |
| | 3 ☐Widowed 4 ☐ Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Detes: | S. 1 | If Yes, spec | | ispanic Origin? (Sp en, Mexican, Puerto Specify: | Rican, etc.) | Bieck, \ | American Indien, White, etc. White | | |
| nd 21215-0 se tilled within 72 ho se tilled within 72 ho se tilled within 72 ho se tilled within 72 ho se tilled within 72 ho se tilled within 12 ho se tilled w | 15. Decedent's E (Specify only highest gr | ducation | 16a. De | ecedent's Usue | Occup | ation during most of work | ina | 16b. Kind of Busin | ess/Industry | | |
| 121 Then the | Elementery/Secondery (0-12) | College (1-4or 5+) | lif | e. DO NOT us | e retired |) | ""y | | | | |
| | 10th | | | Carpen | ter | | | Build: | ing | | |
| B d of the seven | 17. Fether's Neme (First, Middle, Las | | | | 18. Mother's Nam | e (First, Middle, | Meiden Sumeme) | | | | |
| Lyla Menter Ment | | | T | | 12 | Anna Mai | | | | | |
| Maryland d 2 should be like th and Mental Hy 7 is marked oth traumatic event | 19e. Informent's Neme/Reletionship | | | | | | | or, City or Town, Sta | | | |
| CZNS | Anna M. Hughes, | | | rederion (Nem | | oad Apt | Date Thu | 20c. Location - Cit | | | |
| timore, L Pages 1 a timent of Her tant: If Nem sjury or othe | 1 X Buriel 2 ☐ Cremetion 3 [| ☐Removel from Stete | emetery. | cremetory or of | her pled | | | | | | |
| THE POPULATION OF THE POPULATI | 4 Donation 5 Other (Special Signature of Fundrel Service Lice | | lue b | Ridge Co | | ery . | 1/24/00 | Thurmon | t, Maryland | | |
| Ball permit Depart Import Import Import Import | Jan Salation | Javeze | 2 | 1621 0 | poss | umtown P | autter E Lke Fre | derick, l | omes, P.A. Maryland 21702 | | |
| | 20a. Part1. Enter the disease, or con shock, or heart failure. Lishonh | policitions that caused the seat | n. Do not | enter the mode | of dyin | g, such es cardiac | or respiratory er | rest, | Approximete Interval Between | | |
| Physician | | 1 | | 1 | , | | | | Onset and Death | | |
| /Medical | tmmediate Ceuse (Finel disease or condition | | | | | | | | | | |
| Examiner | resulting in deeth) a. Due to (or es e consequence of): | | | | | | | | | | |
| D = - | | h | | | | | | | | | |
| 58760, icate be asscuted physician and s the burial-transit | Sequentially list conditions, Due to (or es e consequence of): | | | | | | | | | | |
| 68760, ficate be available to the burie | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): Due to (or es e consequence of): | | | | | | | | | | |
| 68760, fileste be assecuted g physician and as the bunel-transit | thet initiated events resulting in deeth) Last Due to (or es e consequence of): | | | | | | | | | | |
| O | d. | | | | | | | | | | |
| BOX eath cert attendin for use | Bot II Other straittens conditions continuing to death but out an initial in the underlying to death but out an initial in the underlying to death but out an initial in the underlying to death but out an initial in the underlying to death but out an initial in the underlying to death but out an initial initia | | | | | | | | | | |
| O. of the control of | halt II. Other atgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? | | | |
| of the part of the | | | | | | | 1 Yea 2 No 3 Probably Wunknown | | | | |
| Vital Records, P.O. Box slan: The law requires that the death cer entificate has been signed by the attendin sctor, page 2 should be detached for use Be Completed by PhysicianA. | | | | | | | | an autopsy 2 med? | 24b. Were autopsy findings aveileble prior to completion of cause of deeth? | | |
| The law tee has page 2 | | | | | | | . 10 | res 2□No | (- | | |
| Figure 1 | 25. Was case referred to medical | | | | | oc Blace of Deep | | | 1 Dyos 2□ No | | |
| Series Series | axeminer? | Hospitel: | ED/Outra | atient 3 DO | A Oth | er: 4 D Nursies He | | | (Specify) Scene | | |
| Division of Vital or Attending Physicien: The death. Director: After this certificate in by the funeral director, partification: To Be Control of the Contro | | 28a. Dete of triury | 28b. Tim | | Bc. tnjur Wor | | EST WOOTH TO | now injury occurred | Specify) Scene | | |
| DIVISION C tal or Attending P ts after death. al Director: After ti led in by the funera Certification: | 1 ☐ Neturel 5 ☐ Pending investigetic | on /(Month, Day Year) | 6 30 | PM | 1 🗆 | | suly | it pass | way venice | | |
| /iSi | 3 Suicide 6 Could not l | 286. Pieca of Injury - At h | ome, ferm | , street, factory | , office | /-\ | 28f. Location (S | Street and Number | | | |
| din din | 4 ☐ Homicide | building, etc. (Specif | | lway | | | City of Tol | on, State) Purket | hal + Frankle | | |
| Division of Vital Re To the Hospital or Attending Physician: The Le Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com | 29e. Certifier 1 Certifying P | hysicien: To the best of my kno miner: On the basis of exemine and manner steted. | wiedge, d | eeth occurred | | | | | | | |
| o the omple | 29b. Signature and title of certifier | and manner didied. | | 290 | . Licens | e number | | 29d. Dete signed (/ | Month, Dey, Year) | | |
| F 3 F 8 | 1100 | 1/1: | | | 0 | C.M.E. | | | 20, 2000 | | |
| | 20 Norman de la contra la la contra la la contra la cont | , 1478 us | 00-1 = | D-2-0 | 0. | C.P. E. | | January | 20, 2000 | | |
| | 30. Neme and address of person who | | 1 23a) (Ty | | enn | Street. | Baltimo | re, Marvl | and 21201 | | |
| Carro | 31. Dete filed (Month, Dey, Year) | 32. Registres Signe | ture | | | | | -, | | | |
| State Registrar | a set a | 1 2000 > 3000 | ne | S. | 14 | oak | | | | | |
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State of Maryland / Department of Health and Mental Hygiene 00 04496

| | | | | C | ertifica | ate of | Death | | Rec | . No. | | | | |
|---|--|---|--|--|---|------------|--------------------------|--------------|--|--|----------------------------|--|--|--|
| | | 1. Decedent's Neme (First, Middle, Las | st) | | | | | 18 | 2. Date of Death | | | 3. Tima of Deeth | | |
| | Physician | CLARENCE W. | HAHN | | | | | | Month January | 16, 2 | Year 000 | 10:24 AM | | |
| 100 | /Medical Examiner | 4a Facility Name (If not institution, give | a street and number) | | | | 4b. City, To | | ation of Death | 4c. County | | | | |
| | LAMITHE | Frederick Memo | rial Hospital | | | | Free | deric | k | Free | deric | k | | |
| | Funeral | 5. Social Security Number 6. S | | last birthda | | ler 1 Year | If Under: | 24 Hrs. 8 | B Date of Birth | , , | 9. Birthp | lace (State or Foreign | | |
| | Director | 212-36-6216 Usual Residence of Decedent | © M 2□ F 66 | Yrs. | Month | s Days | Hours | Min. | (Month, Day, Voct. 13, | | Penn | nsylvania | | |
| Maryland | or 28a-f ahow be notflind at Director | 10a. State 10b. County Maryland Frederic | | mmits | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No | | | | |
| 5 | 282 | 10e. Street and Number | IL. | iiiiiI LS | | Tip Code | | | 10g. Citizen of What Country? | | | | | |
| h with | 23a o | 7149 Friends Cree | k Road | | | 217 | 727 | | United States | | | | | |
| 900 | filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or frame 23a or 28a-f ahow not, the Medical Emerican must be notified at the Medical Emerican number Director. Completed by Funeral Director | 11. Merital Status | 12. Was Decedent Ever in U Armed Forces? | J,S. 13 | 3. Was Dec | edent of | Hispanic Origon, Mexican | gin? (Speci | ify Yes or No- | | a - America k, White, o | | | |
| 020 urs after | | 1 Never Married 2⊠ Merried 3 Widowed 4 Divorced | 1 Yes 2 No if Yes, Give Year or Dates: | | 311 | 2 No | | i, rusito ru | can, etc.) | Specify | T 71. | ite | | |
| 2 20 | | 15. Decedent's Ed | | 16a. Dec | cedent's Us | sual Occu | pation during most | e of working | 16 | Sb. Kind of Bu | usiness/Ind | lustry | | |
| 21215-0020 d within 72 hours at | | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5+) | Pair | DO NOT | use retire | ed) | OF WORKING | | Montgo | mery | County | | |
| _ X | 丁台 5 | 17. Father's Name (First, Middle, Last) | | , | | | 18. Mothe | r's Name (| First, Middle, Ma | | | 02.5 | | |
| Maryland | marked of umatic eve | Luther Abraham Ha | hn | | | | Ida | Emma | Jacobs | | | | | |
| Shou shou | end Menta le marked eumatic e | 19e. Informent's Neme/Reletionship (| Гуре, Print) | 19b. Ma | iling Addre | ss (Stree | t and Numbe | er or Rural | Route Number, (| City or Town, | State, Zip | Code) | | |
| , Me | 474 | Margaret M. Hahn | / Wife | | | | | | | | | land 2172 | | |
| e i | 7 5 5 | 20a. Method of Disposition | 20b. i | Place of Dis | position (N | lame of | | Road | | c. Location - | | | | |
| aitimore, | | 1 St Burial 2 Cremetion 3 4 Donation 5 Other (Specific | Removel from Stete | thave | | | l Gard | Ja | 2000 F | rodori | ole N | Maryland | | |
| E = | Department Insportant: If eny Injury or pace. | 21. Signature of Funger Stevice Licen | | | | | | | ffer Fu | | | | | |
| 6 | e e in g | 14/191 | e to | | | | | | | | | land 2170 | | |
| | | 23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only | plications that caused the dealone cause on each line. | th. Do not e | enter the m | ode of dy | ing, such es | cardiac or | respiratory arres | t, | | Approximete Interval Between Onset end Deeth | | |
| 1 | Medical xaminer | Immediate Cause (Finel disease or condition resulting in death) | . A cut | OF AS A COPH | my | elo | gen | 000 | Len | Kem | e | 2 Week | | |
| 50, se exacuted | physicien and a the burlal-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. acut | or as a cons | Di Novi equence o CANO | lia | (in | far | M Si | mara | nel | | | |
| . Box 68760, death certificete be executed | De X | Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d | | | | | | | | | | | | |
| | ed for | Part II. Other significant conditions of | ontributing to death but not re- | resulting in the underlying cause given in Pert I. | | | | | 23b. Did tobacco use contribute to the cause of death? | | | | | |
| S, P.O | igned by the attend to detached for usa by Physician/ | | women with the second of the s | | | | | | 1 Yea 2 No 3 Probably 4 Unknow | | | | | |
| Records | page 2 should b | | | | | | | | 24a. Was an autopsy performed? 24b. Were autopsy tin available prior to completion of car of death? | | | ailable prior to mpletion of cause | | |
| H H | page Com | | | | | | | | 1 ☐ Yes | 2010 | | Yes 2□ No | | |
| | certifica rector, p | 25. Was case referred to medical | | | | | 26. Place | of Deeth | (Check only one) |) | | | | |
| Of VIta Physicien: | direct | examiner? | Hospital: 1 Impatient 2 | ER/Outpat | ient 3 🗆 I | DOA O | hor | | e 5 Residen | ce 6 DOth | er (Specifi | v) | | |
| | After this funeral of | 27. Manny of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time | of | 28c. Inju | | | d. Describe how | | | 7 | | |
| O P | th. tuner tuner | 1 Neturel 5 Pending investigation | | Injury | M | | ork?]Yes 2∐l | No | | | | | | |
| Division or Attending | | 3 ☐ Suicide 6 ☐ Could not be determined | ory, office | | 281. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | | | | | | |
| Hospital | Funer taly fill | | ysician: To the best of my kno siner: On the basis of examins and manner stated. | | | | | | | | | | | |
| To the | within 2 To the comple | 200. Signature and title of certifier | 11/1/ | | 2 | 9c. Licen | se number | ! | 290 | J. Dete signe | d (Month, | Day, Year) | | |
| | > - 0 | 1 Wy MM 1 KanW, MD 1 48184 1/15/2000 | | | | | | | | | | | | |
| | | 30. Name and address of person who | completed cause of death (Iter | n 23a) (Tvn | e, Print) |) | 10 | , - | 1 | 11/1 | | | | |
| | | Elhany Es Kan | 1 | 501 | w - | 7th 9 | treet | FN | rderick | MD | 21 | 701 | | |
| | State | 31. Dete filed (Month, Day Year) | 32. Registry's Sign | | 6 | | / | * | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

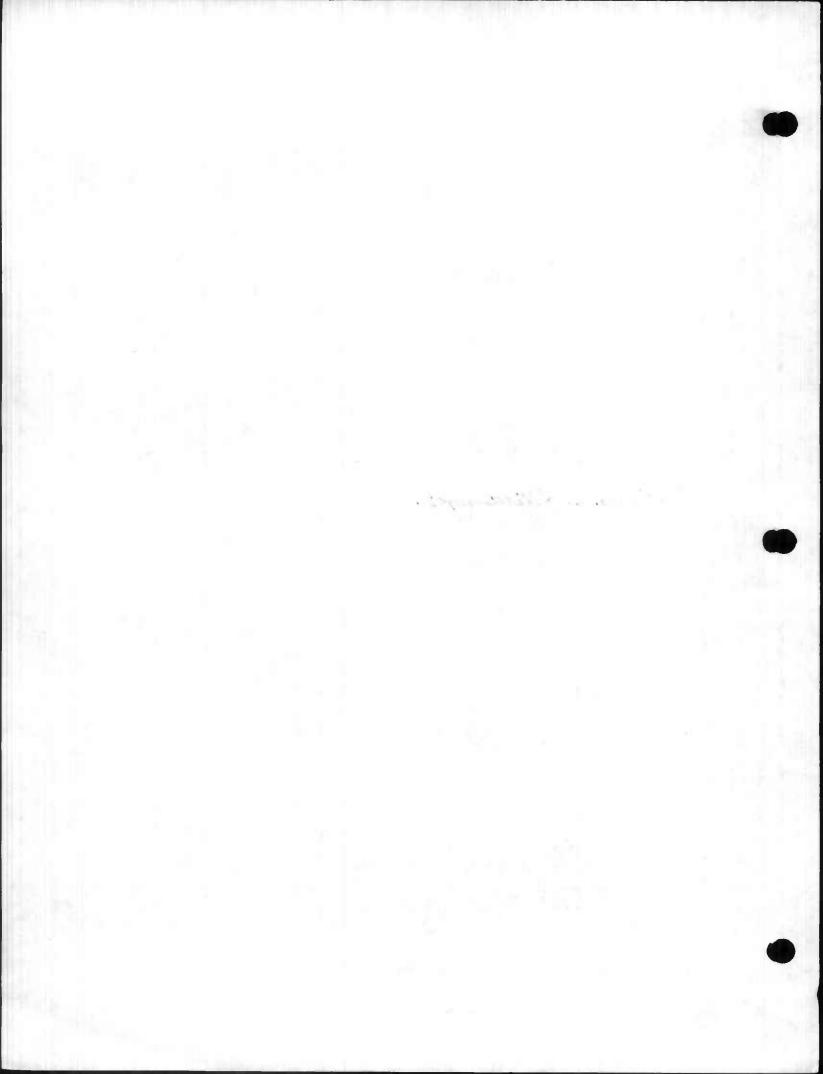
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|--|--|--|--|---------------------------------|---|--|--|---|---|--|-----------------------|---|---|---|---|---|
| nysician | | . Decedent'a Nama | (First, Middla, | Last) | | | | | | | | 2. Data of De Month | | Year | 3. Tima of Death | Ī |
| Medical | | | P. ISR | | | | | | | - C'- T- | | JANUAR | | 2000 | 2:00 A.M. | _ |
| xaminer | 48 | a Facility Nama (# | GOYA DR | 5 35 300 110 | and number | er) | | | 1 | POTO | | cation of Deat | MON | rinty of Death | | |
| neral ector | | Social Security No. 219-04=- | | Sex 1 M 2 | | | last birthday, | Months Months | ar 1 Yaar Days | If Under a | 24 Hrs. Min. | 8. Data of Bir (Month, Di MAY 21 | th ny. Year) 1938 | 9. Birth Col | nplaca (Stata or Foreign unto) LE | |
| | | Isual Residence of Oa. State | Decedent 10b. County MONTGO | MERY | | | ty, Town or L | ocation | | 10d. Inside City Limi | | | | | | |
| at being | 10 | 10e. Street and Number 11824 GOYA DRIVE | | | | | 101. Zip Coda 20854 | | | | | 10g. Citizen of What Country? U. S. A. | | | | |
| cal Examiner must be notified at | 2 | 1 Nevar Married 2√3 Married 1 Yas | | | | No 1 ☐ Yas 250No | | | | ispanic Origin, Maxican Specify: | gin? (Spo , Puerto | ecify Yas or No Rican, atc.) | | Black, White | rican Indian, n, atc. WHITE | |
| umeric event, the Med To Be Comple | - Annaham | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4) 8 YEARS | | | | or 5+) | (Give lifa. | a kind of w | usa retired | during most | of work | ing | 11.0 | BANK | ndustry | |
| | 17. Fathar's Nama (First, Middla, Last) MORIS ISRAEL | | | | | | | | | r's Name | ARDO | | | | | |
| | 11 | 9a. tnformant's Na MIRIAM S | | | | | | | | | | OMAC, M | | | | |
| | 20 | 0a. Mathod of Disp XXBurial 2 □ 4 □ Donation | Cremation 3 | | al from Sta | 10 | Place of Disp cemetery, cra | matory or | othar plac | | IS 2 | Data / 3 / 2000 | | on - City or | Town, Stata RYLAND | |
| DOG | | 1. Signature of Fu | 110 | ^ | | | . D/ | ANZAN | SKY-C | s of Facility | TRC 1 | MEMORTA | I CHAF | FIS | INC | |
| ian cal ner | tin di re | 101 | ld C. la disaasa, or co | omplication by one cau | Blace | der | . D/ | ANZAN L70 R nter tha mo | SKY-C OCKVI oda of dyin | OLDRE | TRC 1 | MEMORIA , ROCKV or respiratory a | AL CHAF | ELS, MARYL | INC. AND 20852 Approximate Interval Batween Onset and Death | |
| s the bunel-fransit and land land land land land land land | 2 th direct Sit care Character than the care care care care care care care car | 23a. Part1. Entar th ahock, or haar mmediata Ceusa (i liseasa or condition | a disaasa, or or tallure. List on final or distinguishment of the control of the | omplication by one cau | s that caus use on each | Due to (| th. Do not en | ANZAN L70 R ter tha mo | SKY-COCKVI OCKVI ode of dyin | OLDRE | TRC 1 | MEMORIA • ROCK V for respiratory a | AL CHAF | ELS, MARYL | AND 20852 Approximate Interval Batween Onset and Death | |
| eleched for use as the bunal-transit au pur la la la la la la la la la la la la la | 2 thinding re | 23a. Part1. Entar the shock, or hear memodiate Ceusa (i disease or condition esulting in death) Gequantially list corrany, laading to impuse. Enter Undarause. Enter Undaraus intiated events | a disaasa, or or trailure. List on trailure. Lis | a b d | s that cause on each | Due to (c | th. Do not en | ANZAN L70 R Industry that moder that modern industrial and the modern that mod | SKY-COCKVI OCKVI oda of dyin | GOLDBE LLE F g, such as | TRC 1 | , ROCK V | 7IIIE, | MARYL | AND 20852 Approximate Interval Batween Onset and Death | |
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State Registrar

31. Data tiled (Month, Day, Year) FEB 04 2000

BRUCE R. KRESSEL, M. D.

5480 WISCONSIN AVENUE, SUITE 214, CHEVY CHASE, MD. 20815



| State of Maryland | / Department of | Health and | Mental Hygiene |
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| 1 1 | July 1 | LA | - | (1) |
| | - | | -1 | 1 |

ITEM # 19a, 19b. 2/7/2000 CCHD FCB

Certificate of Death

| | , | | | | Certii | icale of | Dealli | | Re | g. No. | | |
|--|--|---|---|---------------------------|-----------------------------|-----------------------------------|------------------------------|-----------------------------|---|-----------------------------------|--------------------------|---|
| Physic /Med | | Decedent's Neme (First, Middle, Las Charles J. | Johnson | | | | | | Date of Deetl Month JANUARY | Dey | Yeer 000 | 3. Tima of Deeth 5:15AM |
| Exami | | 4e. Facility Name (If not institution, give St. Marys Hospi | tal | | | | Leon | ardto | on of Death | 4c. County | Mar | ys |
| Funeral Director | | 5. Social Security Number 6. Si 213-38-2710 Usuel Residence of Decedent | ax 7. Ag □M 2□ F | e (In yrs. last bii | | Undar 1 Yaar onths Deys | | Min. | Dete of Birth (Month, Day, rember | | 9. Birthp | lece (Stete or Foraign try) .ryland |
| arylend show | | 10e. Stete 10b. County | | 10c. City, Tow | vn or Locati | on | | | | | 1 | 0d. Inside City Limits |
| he Ma 28a-f s | Director | Maryland St.Mar | ys | | Bushw | | | | | | | Yas 2□No |
| with t | | 10e. Street end Number 23116 Woodbush | Drive | | | 20618 | | | 10 | 10g. Citizan of What Country? USA | | |
| fied within 72 hours after death with the Marylend thygiene. ther than "natural", or items 23s or 28s-f show ort, in Medical Examiner mant be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married | 12. Wes Dacedent Ever in U,S. Armed Forces? 1 \[\text{Yes} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | Decedent of s, specify Cub | | | y Yas or No- an, etc.) | 14. Rac Bled | e - Americ ck, White, | |
| 72 hours aft "natural", or | | 3 Widowed 4 Divorced | | | | Specify | Bla | | | | | |
| in 72 in ab | olete | 15. Decedent's Ed (Specify only highest grad | de completed) (Give kind of work done life. DO NOT use retire | | | | petion during mos ed) | t of working | 1 | 16b. Kind of Bu | isiness/inc | dustry |
| d with giene. | is 1 end 2 should be of Health end Mental item 27 is merked of | Elementary/Secondery (0-12) Collega (1-4or 5+) 1.2 Truck Driver | | | | | | | B | . K M | illa | r |
| d 2 should be file th end Mental Hy 7 is marked othe traumatic event, | | 17. Fether's Name (First, Middle, Last) | Unknov | | | | 18. Mothe | | irst, Middle, N | laiden Surnam | | |
| Pages 1 end 2 sho nent of Health end nt: if item 27 is me iry or other traums | | Unknown 19a. Informant's Neme/Relationship (Type, Print) EDNA JOHNSON / WIFE ELSIE Johnson / 15433 Covington Rd, Brandywine Maryland 20a. Method of Disposition 1 Quiriel 2 Cremetion 3 Removel from Stete | | | | | | | | | | 20613 |
| permit. Pages 1 e Department of He Important: if item any injury or othy once. | | 4 Donetion 5 Other (Specify 21. Signature M Funerel Service Licen: | S 00 | rger! | 22. Na | ame end Addr | ess of Fecilit | ty | | 00 He | | 20608 |
| 00 = 4 O | | Thyl 50 | | | | | | | | | co M | aryland |
| Physician /Medicai | ı | 23a. Pert Enter the Common Common Shock, or heart failure. List only Immediate Ceuse (Final | | | | ne mode of dy | ing, such es | cardiac or re | espiratory arre | st, | | Approximate Intervel Between Onset end Deeth |
| Examiner | | disease or condition resulting in deeth) Due to (or es a consequence of): | | | | | | | | | | |
| pg #5 | liner | | b. CHRON | io ani | muctin | e Pu | 4M DIMM | a po | was | | i | |
| certificate be executed ming physician and use es the bunal-transit | cai Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events | nca of): Ohy Uhrry nca of): | | | | | 1 | | | | |
| h certificete be ex anding physician use es the buna | in/Medicai | resulting in deeth) Last | Due to (or es e consequenca of): 1 | | | | | | | | | |
| The law requires that the death ate hes been signed by the etter page 2 should be deteched for | by Physicia | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | | 23b. Did tobacco use contribut | | |
| he law requires the hes been signed | Completed b | | | | | | | | 24a. Wes er perform | | COI | ere eutopsy findings eileble prior to mplation of cause death? |
| | Соп | | | | | | | | 1□ Ye | s 2 No | 10 | Yas 20 No |
| Physicien: The this certificate rel director, pag | Be | 25. Wes casa raferred to medical axaminer? | Hospital: | | | | hor | | Check only one | | | |
| Phys this rel di | tion: To | 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigation | 28e. Dete of Inju (Month, De | ry 28b. | Time of Injury | 28c. inju | 4 🗆 140 | 280 | | nca 6 □Oth w Injury occuri | | y) |
| X = = c | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 286. Place of Inju | | | | | | 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) | | | |
| To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by | edical C | 29a. Certifier (Check only one) Certifying Phy | sician: To the best of iner: On the basis of end manner ste | examinetion an | e, deeth oc nd/or Invest | curred at the ti getion, In my | ime, date en opinion, dee | d plece, end th occurred | I due to the ca at the time, da | use(s) and ma ite end placa, | nner as st end due to | tated. the cause(s) |
| To the Within To the comp | Me | 29b. Signature and title of certifier | Ohmin | ~ | | 29c. Licen | se number | 7 | 29 | d. Date signe | d (Month, | |
| | | 30. Name end eddress of person who c | | eath (Item 23a) CALIF(| | • | 20619 | | | | | |
| Sta Regist | | 31. Dete filed (Month, Dey, Year) FEB 0 3 | | s Signetura | B. | , | nds | | | | - | |
| | - | | | | | | | | | | | |

CHARLES JOSEPH JOHNSON



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Yain ola OVNES 00 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hall POCOMOKO or If Under 24 Hrs. 8. Ursing Homo Home Hartley H 5. Sociel Security Number Worcester If Under 1 Yeer 6. Sex Birthplace (State or Foreign Country) **Funeral** 172-22-9956 1 M 2 F Months Days Hours Min. Yrs. Director MD Usuel Residence of Decedent 10a. State 10b. County item 27 is marked other than "naturs!', or items 23a or 28a-f show other traumatic event, the Madical Examiner names on notified at 10c. City, Town or Location 10d. Inside City Limits Pocomok 1 Yes 2 No Directo Norcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Second U.S. 906 A Street 185 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 to No if Yes, Give 7 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status Raca - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: P 3 Widowed 4 □ Divorcad Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use ratired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traument. Eiementery/Secondary (0-12) College (1-4or 5+) 15+ grade 17. Father's Name (First, Middle, Last) Worker 18. Mother's Name (First, Middle, Maiden Sumame) Be Mason 2210 UNKNOWN -euin 19e. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NIECE) 906 A - Second

20b. Placa of Disposition (Name of camelery, cramatory or other piece) Pocomoke Beatrice noke City Md, 2185, 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from Stete St. Paul Cemetary 1-29-00 Stockton Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
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20. Name and Address of Facility 21. Signature of Funeral Service Licensee Bervie Smith Funcral Hame Plo, Box 331 Pacamake City, Md. 2185, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximately approx **Physician** /Medical Immediate Cause (Fine disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest burial-tran Box 68760, Physician/Medical the attending I use as signed by the all P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed by 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? After this cartificata 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Plece of Deeth (Check only one) Certification: To 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name end ddress of person who completed cause of death (item 23e) (Type, Print) M. BELLOSO, M. D.; 5302 CHINABERRY DR; SALISBURY, MD Z 1801 GREGORIO 31. Date filed (Month, Day, Year)

32. Registrar's Signature

3 JAN

State Registrar

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Handley half Numerica Holis (Cookare Village Park) Don't Le Worker bestern Fryer Lines) Marit Securit Street Marenelle (1, 1902 1855) It for Courtsey 1-29 to Stock Low 181 de

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State of Maryland / Department of Health and Mental Hygiene

\(\) 04500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Griffith Jackson 30, 2000 January 1:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ÅF Months Days Hours Min 456-14-3297 84 Sept. 21, 1915 Director Texas Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show the Marvia r than "natural", or lierns 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? 14416 Ash Court 20853 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 🖫 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à White 3 Nidowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene."n Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be fitted w Department of Health and Mental Hygien Important; if flom 27 is marked other this any injury or other the Homemaker Own Home 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Clement Griffith Virginia Griffin 0 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14416 Ash Court, Rockville, Maryland 20853 Hallie Kerr/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 1. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 2000 ROBERT A. Fumphrey Funeral Hom 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Lidenses Funeral Home/Bethesda-Chevy nue Chase, Inc. 211 M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Adenocarcinoma of the Lung 2 months Examiner Due to (or as a consequence of): Examiner bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician certificate be Physician/Medical the Due to (or as a consequence of): 88 esn Pert ff. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 100 detached signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Deen 185 **page 2** certificate L 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 2 1 Yes 2 No this funeral To the Heapital or Attending Phi within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 DiNetural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the lime, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier miner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of contile 29c. License number 29d. Date signed (Month, Day, Year) D0037620 January 30, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Godec, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 2000 Uner

Registrar **DHMH 16 Rev 6/95**

Box 68760. P.O. Records.

